ABSTRACT
AFRICANA WOMEN'S STUDIES
CRICHLOW-SCALES, VENA R. B.S. SYRACUSE UNIVERSITY, 1986
AN EXAMINATION OF REPRODUCTIVE RIGHTS AMONG AFRICAN AMERICAN ADOLESCENT FEMALES

Advisor: Jacqueline Howard-Matthews, Ph.D.
Thesis dated December, 1998

This study examines reproductive rights issues among African American adolescent females who are at risk for unintended pregnancy and HIV infection. The study sample for this study consisted of 37 African American adolescent females, residents of Atlanta, Georgia. Quantitative and content analyses were used to analyze data extracted from focus groups. A survey instrument, focus group guide, coding and analysis system were developed.

The conclusions drawn from this research indicate that African American adolescent females: 1) have moderate to high levels of HIV prevention knowledge and 2) use contraceptive measures such as condoms, Norplant and Depo Provera to prevent pregnancy. In the study population, preventing pregnancy is the main concern. Condoms were used primarily to prevent sexually transmitted diseases, not to prevent pregnancy. Therefore, contraceptive technologies that most effectively prevent pregnancy are common. Methods such as Depo Provera and Norplant which are considered viable solutions to preventing pregnancy have compromised the reproductive autonomy of these young women because

they ultimately deny the user full control over her reproductive health as they do not prevent STDs.

The researcher concluded that because of the historical perception of African American women and their sexuality, preventing pregnancy among African American adolescent females has become an important focus in their reproductive health agenda. Strategies that seek to reduce the rate of unintended pregnancy ultimately force African American adolescent females into a position of powerlessness and deny them control over the reproductive health of African American adolescent females.

AN EXAMINATION OF REPRODUCTIVE RIGHTS AMONG AFRICAN AMERICAN ADOLESCENT FEMALES

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF ARTS

BY

VENA RUBY CRICHLOW-SCALES

AFRICANA WOMEN'S STUDIES DEPARTMENT

ATLANTA, GEORGIA

DECEMBER, 1998

R= V T= 145

ACKNOWLEDGMENTS

As the author, I wish to give thanks to the ancestors and the Creator for guidance and strength in completing this project. I would also like to thank my parents for their continuous encouragement in all that I do, my sister for her faith and my brother for his support. This could not have been done without the encouragement of my husband, Mausiki and our daughter, Nzali. Thank you both for believing in me when I doubted myself. There are a multitude of professors, mentors and friends who encouraged and pushed me. Special thanks to Dr. Jacqueline Howard-Matthews for constantly challenging me, Dr. Patricia Rodney for your subtle strength, Dr. Murty and Dorothy for always seeing the bright side. I would also like to thank the sisters from the West End Medical Centers and the Center for Black Women's Wellness for their assistance in helping to make this happen. This project is dedicated to all the Africana women who have gone before me; it is on your shoulders that I stand.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

In the United States, the health of adolescents is an issue of increasing concern. Two of the major health problems of this population are related to sexuality - unintended pregnancy and infection with sexually transmitted diseases (STDs). Both unintended pregnancy and infection with a STD indicates unprotected sexual intercourse. Although the rate of unintended pregnancy among adolescents has declined over time, STD rates , including those of human immunodeficiency virus (HIV), have increased among adolescents and young adults. In fact, incidence rates of STDs have increased so much that public health scientists have identified adolescents as one of the fastest growing groups infected with HIV. Therefore, in addition to the possibility of pregnancy, unprotected sexual intercourse also increases the possibility of adolescents contracting HIV.

Reproductive rights is a term that is very popular but is often interpreted differently. In general, reproductive rights refer to rights to assure full control over one's reproduction. This includes access to safe and effective reproductive health services, contraceptive use and the choice of whether or not to reproduce. This term is frequently used in reference to adult women, neglecting the rights of all women of childbearing age. Because pregnancy and

STD infection among adolescents are significant issues, the platform of reproductive rights can be appropriately applied to adolescents.

There have been a multitude of studies that have looked at unintended pregnancy. Researchers of this issue among African American adolescent females have identified serious consequences for adolescents who experience pregnancy. However, they have not examined the full impact of unintended pregnancy on all aspects of the lives of adolescents. For the most part, these scholars have approached the topic from a traditional perspective, looking at the health outcomes of the mother and her child or the socioeconomic consequences of teenage mothers. Other scholars have examined this topic from a more sociological perspective, identifying predisposing factors that may increase the chances of being pregnant during adolescence. Some scholars have broadened their research to include methods of pregnancy prevention that are utilized by adolescents who access family planning services. Although the latter approach offers more depth, it fails to include gender issues. The issue of gender appears to impact contraceptive decision-making and ultimately one's reproductive rights. Furthermore, research in the area of adolescent reproductive health has not approached the topic to include the meaning and practice of reproductive rights for adolescents. This realization was the catalyst for the current study.

This study provides an examination of the factors that inform and influence reproductive rights for African American adolescent females who are at greater risk for unintended pregnancy and HIV infection in Atlanta, Georgia. It also seeks to offer a unique perspective on the issue of reproductive rights as it relates to African American adolescent females at greater risk for unintended pregnancy. This is accomplished through an investigation of contraceptive use, including condom use, HIV/AIDS, and the impact of

gender on the reproductive behavior of African American adolescent females. Investigations of sexual knowledge, attitudes and behaviors, particularly condom use and HIV/AIDS knowledge, are intended to enhance the study of the state of reproductive health among the target population. By incorporating gender and the socio-historical context into this analysis, a holistic perspective of the affairs of African American adolescent females shall be developed.

Adolescent females are often excluded from woman-centered research, however their experiences are an integral part of the health of a community. Historically, the voices of women of African descent have been silenced, especially in reference to reproductive rights. African American women were often the targets of policies aimed at control over reproduction. In order to maintain control, gender and racial barriers were present which prevented reproductive autonomy from being actualized. Consequently, these women's needs and desires were not regarded as worthy of consideration.

Purposes

The primary motivation for the current study is based on the realization that the reproductive health of African American adolescents is being jeopardized. Prior research reported that African American adolescent females use contraceptives to prevent pregnancy. The most commonly used contraceptives in this age group are long-term methods such as Depo Provera and Norplant. Although these methods have proven effective in preventing pregnancy, they do not offer protection against STDs. Although preventing pregnancy among adolescents is important, the methods by which prevention is accomplished should be equally important, since preventing pregnancy while jeopardizing other aspects of

be equally important, since preventing pregnancy while jeopardizing other aspects of reproductive health denies adolescents the reproductive right to maintaining health.

The purposes of this study are to: (1) examine the dynamics of unintended pregnancy among African American adolescent females with particular attention to their reproductive behavior; (2) determine the level of HIV prevention knowledge and condom use among the target population; (3) identify how gender influences condom use; (4) provide historical documentation of specific efforts to control the reproductive behavior of African American women and (5) determine how contraceptive use and gender have impacted reproductive rights and the meaning of this term as it relates to the reproductive health of African American adolescent females.

Focus of the Study

The study population consists of 37 African American females who reside in the metropolitan area of Atlanta, Georgia. All of the study participants live in underserved communities and are at risk for unintended pregnancy.

Methodology

The research design employed in this study included both quantitative and qualitative methods. Quantitative data were collected using questionnaires issued prior to each focus group. All focus group participants were asked to fill out a 30-question survey instrument. The instrument measured: HIV prevention knowledge, condom use, impact of gender on condom use and obtained basic demographic information from each participant.

After the survey instrument was collected, 5 focus groups were conducted. This qualitative data collection method documented and validated the experiences of African American adolescent females. The target number of focus groups was five, with the anticipation that there would be no more than fifteen participants in each group. After all the data were collected, 37 adolescent females had participated in the research. The age range of the participants was between 13 and 22.

Strengths

The strength of this research was the study design. The researcher collected quantitative and qualitative data from the study population. The method of data collection prevented double participation. Therefore, double representation was controlled. The data collected in the current study contributes to the existing body of knowledge and literature on health behaviors among African American adolescent females. It provides an understanding of the multitude of factors that are related to reproductive rights and condom use among a culture that has high rates of STDs and unintended pregnancies. This information also contributes to programs and policies that seek to empower African American adolescent females to develop and maintain reproductive control over their lives. It is intended to shed light on the reproductive health care needs of African American adolescent females in an urban area who are at greater risk for HIV infection and unintended pregnancy. Therefore, a goal of this research is to improve the health of African Americans, particularly adolescent females, by providing information that can inform the development of effective health education policies and prevention education programs for the target population.

Limitations and Obstacles

This study focuses on a particular group of African American adolescent females who reside in the metropolitan Atlanta area. Therefore, generalizations about this population should be made with caution. Another consideration is that the researcher does not have access to the clinical information that would allow for the comparison of data with medical history. This study also does not ascertain the type or length of sexual relationship the young women may be involved in (e.g., new relationships or the length of the relationships.) Finally, self-report can result in false reporting of sexual behavior and practices, for a topic as sensitive and as private as sexuality. Future research into this issue should include larger samples or distinct categories of adolescents and obtain information on the nature of their sexual relationships in more detail.

It was anticipated that there would be more respondents in the study, particularly for the analysis of quantitative data. However, the arrangements that were made by the host organizations did not allow for the anticipated ten to fifteen participants per focus group who were at least thirteen years of age. Although attempts were made to schedule additional focus groups with the host agencies, this did not happen.

Definition of Terms

The following terms will be used in the current study:

1. **Consistent condom use:** refers to whether or not respondent uses a condom each time she has sexual intercourse. This will be assessed by the survey instrument.
2. **Depo-Provera**: Depo-modroxy progesterone acetate (DMPA) or Depo-Provera is a long acting synthetic hormone (progesterone) administered by injection in three month intervals.
3. **Dual Contraceptive use**: Use of long-term contraceptive methods such as Depo Provera, Norplant or oral contraceptives and condoms.
4. **Female-controlled contraceptive methods**: contraceptive methods whose use is controlled by women. In this research, these methods are identified as oral contraceptives, Norplant and Depo-Provera.
5. **Gendered division of contraceptives**: contraceptive choices of females and males correspond to gender roles prescribed by society. These choices are based on gender roles.
6. **Knowledge**: measured by level of HIV prevention knowledge of study participants. The number of correct answers to questions related to HIV prevention and transmission will assess knowledge.
7. **Male-controlled methods**: contraceptive methods whose use is controlled by males; specifically condoms.
8. **Non-barrier methods**: contraceptive methods that do not provide a layer of protection between sexual partners. In this research, these methods are

identified as Norplant implants, Depo Provera and oral contraceptives. The primary role of these methods are often pregnancy prevention, a responsibility which is perceived as the woman's.

9. **Norplant**: long-acting synthetic hormonal contraceptive administered through six match stick-sized silicone implants inserted into the upper arm. Protection from pregnancy is provided 24 hours after the implants are inserted and may last for as long as five years.

10. **Reproductive rights**: the right to choose to have or not have a child, the right to the full range of contraceptive services and appropriate information about reproduction; the right to male informed choices; the right to easily accessible health care that is proven to be safe and effective; the right to reproductive health and the right to make individual reproductive choices.

11. **Sexually transmitted diseases**: refers to infections and/or viruses that are transmitted through sexual activity. This includes HIV infection.

12. **T-cell**: a type of white blood cell essential to the body's immune system; helps regulate the immune system. The level of T-cells in a HIV positive person serves as an indicator of the progression of HIV infection.

13. **Unprotected sexual intercourse**: engaging in sexual intercourse without the use of a barrier method such as a latex condom.

14. **Vertical transmission**: refers to transmission of the human immunodeficiency virus from mother to infant during pregnancy.

CHAPTER 2

THE DYNAMICS OF UNINTENDED PREGNANCY

This study will provide an examination of reproductive rights issues among African American adolescent females who are at greater risk for unintended pregnancy and HIV infection in Atlanta, Georgia. This examination will be done through an investigation of contraceptive use, condom use and HIV/AIDS knowledge level among African American adolescent females. Investigating the sexual behavior patterns, particularly condom use, and HIV/AIDS knowledge of African American adolescent females is important in that it will inform a holistic analysis of the state of reproductive health as well as the affairs of African American adolescent females in general.

This chapter outlines the summation of unintended pregnancy and its impact on adolescent and young adult females in the United States. It includes a review of the data on unprotected sexual intercourse among adolescents, contraceptive use and non-use among adolescent females as well as the consequences of unprotected sexual intercourse[1] for adolescents and young adults. This is done in order to provide a description of the problem among all youth and to illuminate racial and gender comparisons in order to further highlight the situation among African American youth. The latter part of this chapter focuses on the sexual behavior, contraceptive use, including condom use, and the impact of these activities

[1]See Definitions section for further explanation.

on the lives of African American adolescent females, using the study participants as case studies.

Each year an increasing number of adolescent females engage in unprotected sexual intercourse. Unfortunate consequences of this practice are unintended teenage pregnancy and infection with STDs, including HIV infection. For women, using an effective method of contraception and a condom is necessary to prevent unintended pregnancy and STDs because they most often bear the brunt of unintended pregnancy and there is no vaccine or cure for HIV or AIDS. In addition, given that dual contraceptive use[2] is paramount to pregnancy and HIV prevention, effective contraceptive use also serves as an indicator of exercising reproductive rights,[3] an integral part of maintaining reproductive health for adolescent women.

As suggested in numerous studies, there is an increasing prevalence of sexual activity among adolescents, with the age of the first sexual encounter among adolescents significantly decreasing over the last four decades. According to a 1994 study by the Alan Guttmacher Institute (AGI), more than 50 percent of women and almost 75 percent of men in the United States reported having sex before their eighteenth birthday. In the mid-1950s, just over a quarter of women under age 18 reported having sexual intercourse.[4] In 1994 there were more teenage men and women reporting sexual experiences at each age between 15 and 20 than

---

[2]See Definitions section for further explanation.

[3]See Definitions section for further explanation.

[4]Alan Guttmacher Institute, Sex and America's Teenagers (New York:Alan Guttmacher Institute, 1994) , 4.

in 1970.[5] Adolescent sexual behavior and its consequences, namely unintended pregnancy and STDs, have been issues of increasing concern since these behaviors demonstrate a significant impact on the social, economic and health status of adolescents in their transition into early adulthood.

Unintended Pregnancy Among Adolescents in the United States

Rates of unintended pregnancy are much higher in the United States than in many other developed nations.[6] Compared with adolescents in other developed countries, adolescent females from the United States are five times more likely to become pregnant and experience a birth than their counterparts abroad. The birthrate among this group has also increased steadily since 1990.[7] According to AGI, almost one million teenage females become pregnant annually in this country.[8] This means that one out of ten girls under the age of twenty get pregnant each year.[9] Of the 1,000,000 that become pregnant, 85 percent of these are unintended. Of these, 8 percent occur among 14 year olds, 18 percent among teens between the ages of 15 and 17 years and 22 percent among teens aged 18-19 years. There are also differences in the rates of childbirth between white and black adolescents. In the United

---

[5]Ibid., 19.

[6]Ibid., 76.

[7]Stephen Caldas and Mike Males, "Teen Pregnancy: Why it Remains a Serious Social, Economic and Educational Problem in the U.S.--Comment/Reply," Phi Delta Kappan 75, no. 5 (January 1994) : 402-410.

[8]Alan Guttmacher Institute, 4.

[9]Lilly Langer, Rick Zimmerman and Jennifer Katz, "Which is More Important to High School Students: Preventing Pregnancy or Preventing AIDS?" Family Planning Perspectives 26, no. 4 (July 1994) :154.

States, white adolescents account for 68 percent of unintended pregnancies, while African American teenagers experience higher rates of childbirth and increased poverty as a result of adolescent pregnancy.[10]

Some of the major consequences of an adolescent's unintended birth are: reduced formal education, underemployment, unemployment and limited or decreased income generation. Women who give birth as teenagers eventually have a median family income well above poverty, though lower than that of women who are older when they have their first child. Women who are older when they have their first child are often married and have a higher level of education, thus allowing them to have a higher income level than their younger counterparts. A consensus of the literature shows that teenage mothers are likely to have inadequate formal education, experience underemployment or sustained unemployment and earn an income that does not meet their needs.

Table 1 presents statistical data on unintended birth and median family income among adolescents. This table shows that for adolescents who give birth and are under 19 years of age, the average household income is slightly below $18,000 annually. For women who are between the ages of 20 and 24, household income level increases slightly to about $24,000 a year. For those women who have their first child after the age of 25, the median annual household income is the highest at $36,400 annually. This suggests a direct correlation between unintended pregnancy and economic quality of life.

Adolescent childbearing is most commonly reported among young women from lower socioeconomic groups, with 80 percent of children born to adolescent mothers

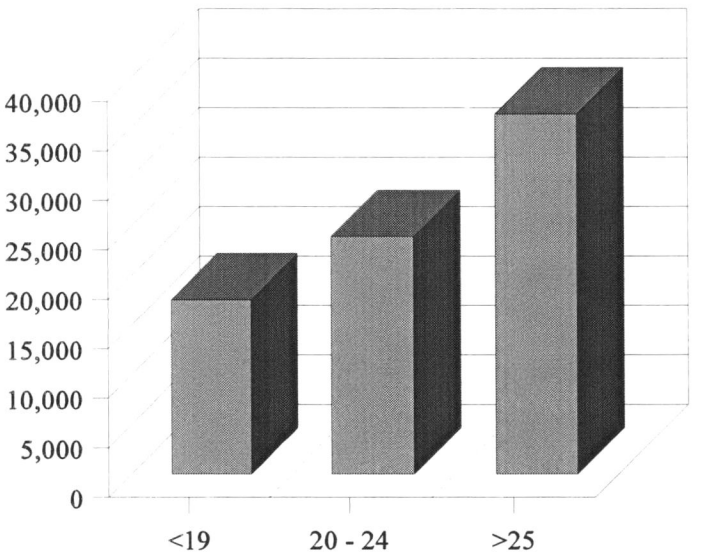
---

[10]USA Today: The Magazine of the American Scene, January 1994, p. 11.

coming from disadvantaged backgrounds.[11] For these teens, the cycle of poverty continues later in life. According to the AGI , long-term results of an unintended pregnancy are largely determined by the socioeconomic status of the mother.[12] Teen mothers are reported to earn about half of the lifetime income of women who postpone childbearing until their early

TABLE 1

TEENAGE MOTHERS' INCOME IN LATER LIFE



Source: Alan Guttmacher Institute, Sex and America's Teenagers (1994)

---

[11]Alan Guttmacher Institute, 4.

[12]Ibid.

twenties.[13] Furthermore, 28 percent of teen mothers are poor in their early twenties and through their thirties. Although 70 percent of teen mothers complete high school, they often do not pursue a college degree.[14] Armstrong and Pascale stated that teenage mothers who give birth are less likely to receive a high school education.[15] A study also indicated that almost 40,000 young mothers drop out of school annually because of childbearing.[16] Data from an AGI study showed that 29 percent of women have completed grades 1-11, 15 percent have completed some college, 5 percent have a college diploma and 51 percent have a high school diploma. In short, unintended pregnancy carries corollaries that negatively impact the socioeconomic status of teenagers and young adults. In addition to the limited social and economic choices of adolescents, unintended pregnancy may also result in poor health outcomes for young mothers.

Another impact of unintended pregnancy on adolescent females is a poor status of reproductive health. Younger adolescents experience more pregnancy and post-partum complications as compared to older adolescents. Birth among teens under the age of 15 have higher rates of infant mortality, low birthweight and pregnancy complications. The probability that the teenage mother will experience a repeat pregnancy also increases.[17]

---

[13]Ibid., 1.

[14]Ibid.

[15]Elizabeth Armstrong and Alicia Pascale, Pregnant and Parenting Teens Face Health Risks, Academic Failure and Poverty (Washington, DC: Center for Population Options, 1990) , 1.

[16]Ibid.

[17]Nancy Leland et. al. "Variations in Pregnancy Outcomes by Race Among 10-14 Year Old Mothers in the United States," Public Health Reports 110, no. 1 (January 1995)

Adolescents under the age of 20 have higher rates of preterm delivery, miscarriages, stillbirths, prolonged labor, maternal death rates and other pregnancy complications.[18] Moreover, coupled with the adverse pregnancy outcomes that result because of the age of the mother, there are also other health problems that may arise as a result of unprotected sex in this group. For instance, high rates of gonorrhea, syphilis and HIV among adolescent females serve as evidence of unprotected sexual intercourse among this group. According to Morris (1993), pregnancy and STDs, including HIV infection "cause significant health, social and economic problems for adolescents."[19]

Of the estimated 12 million new cases of infection with STDs annually, 86 percent of these cases occur among people between the ages of 15 and 29.[20] The most commonly reported STD among this age group is gonorrhea, although rates are notably higher for non-white females aged 15-19.[21] When left untreated, gonorrhea may lead to pelvic inflammatory disease (PID). The rates of PID are highest among adolescents, and the risk of developing this disease among sexually active 15 year olds is one in eight.[22] PID poses additional problems to the reproductive health of females, including adolescents. For example, females who are diagnosed with PID are at an increased risk for recurrent PID, chronic pelvic pain,

---

: 53.

[18]Ibid.

[19]Leo Morris, Charles Warren and Sevgi Aral, "Measuring Adolescent Sexual Behaviors and Related Health Outcomes," Public Health Reports 108, suppl. 1 (1993) : 31.

[20]Ibid.

[21]Ibid.

[22]Ibid., 32.

involuntary infertility and ectopic pregnancy, all problems that may present themselves later on in life.[23]

Infection with a STD places one at greater risk for HIV infection. Statistics show that HIV prevalence rates are higher among individuals ages 20-29, with a considerable percentage of the total AIDS cases being diagnosed in individuals in their twenties.[24] Many of these individuals have also been diagnosed with a STD. Given the high rates of STD infection and that the length of time between infection and symptoms may be as long as 10 years which allows time for disease transference to one or more sexual partners, many of these young adults were infected with HIV and other STDs during adolescence. Therefore, epidemiologists have recently identified adolescents as a risk group for HIV.

A number of epidemiological studies report the HIV infection rate in those under the age of 22 as high as one in four.[25] AIDS is currently identified as the sixth leading cause of death for people between the ages of 15 and 24. The increasing number of AIDS cases reported each year in this age group has escalated by 417 percent from 1981 to 1994.[26]

AIDS is now recognized as the fourth leading cause of death in the United States among women between the ages of 25 and 44, with exposure by heterosexual contact listed

---

[23]Ibid.

[24]Freya Sonenstein, Joseph Pleck and Leighton Ku, "Sexual Activity, Condom Use and AIDS Awareness Among Adolescent Males," Family Planning Perspectives 21 (1989) : 152.

[25] Peter S. Rosenberg, Ralph Biggar and James Goedert, "Declining Age at HIV Infection in the United States," New England Journal of Medicine 330 (1994) : 789.

[26]U.S. Centers for Disease Control and Prevention, "What Are Young Gay Men's HIV Prevention Needs?" (Atlanta: Centers for Disease Control and Prevention National AIDS Clearinghouse, 1996) , 1.

as the leading mode of transmission. The trends in the epidemic of women are closely associated with the epidemic in children; as the rate of infection has increased in women, it has also increased in children. In 1994, 1,017 pediatric AIDS cases were reported. This represented an 8 percent increase from the number reported in 1993. In this same year, an estimated 7,000 (1 in 625) HIV-infected women gave birth in the United States. With the perinatal transmission rate at 15-30 percent, it is estimated that about 1,000 to 2,000 infants were born HIV positive in 1993. [27]

Unintended Pregnancy and African American Adolescent Females

Social scientists have developed a profile of an adolescent female who has an increased chance of experiencing an unintended pregnancy. They are: urban, black, members of a large single-parent family in which the mother or sister was a teen parent and low socioeconomic status.[28] Statistics demonstrate that the majority of adolescents (83 percent) who give birth are from poor or low income families.[29] For African American females between the ages of 15 and 19, both pregnancy and birth rates were almost three times higher

---

[27]U.S. Centers for Disease Control and Prevention, "CDC Fact Sheets" (Atlanta: Centers for Disease Control and Prevention National AIDS Clearinghouse, 1996) , 5.

[28]Bess Jones, "Repeat Teen Deliveries in Fulton County," Journal of Adolescent Growth 78 (January 1989) : 31.

[29]Alan Guttmacher Institute, 58.

than the rate for white females.[30] During the last decade, youth from disadvantaged backgrounds were found to be at greater risk for unintended pregnancies.[31]

Poor and low income adolescents have also been found to be more likely to be sexually experienced, although this difference has not been proven to be true among racial and ethnic groups. About 50 percent of young women from low income families report having had sex by age 17, about four months earlier than adolescent females from higher income families.[32] As compared to white adolescents, low income African American youth have been found to have the highest teen pregnancy rates among unmarried adolescents in the United States.[33] (Table 2) Furthermore, African American adolescent females are more likely to become pregnant at an earlier age than their white counterparts.[34]

Georgia leads the nation in the highest rate of unintended pregnancy among adolescents, with the metropolitan Atlanta area reporting some of the highest rates in the

---

[30]Kids Count, Missouri, "African-American Teens Face Much Higher Risks for Pregnancy and Birth", (St Louis, MO: University of Missouri-St.Louis, 1996) , 1.

[31]Leland, 51.

[32]Ibid., 4.

[33]Phyllis Kuzlel-Perri and John Snarey, "Adolescent Repeat Pregnancies: An Evaluation Study of a Comprehensive Service Program for Pregnancy and Parenting Black Adolescents," Family Relations 40 (October 1991) : 381.

[34]Kids Count, Missouri.

state.[35] In 1993, 25,385 young women ages 10-19 became pregnant, with 1,013 of these pregnancies occurring to teens less than 15 years of age.[36]

The rate of HIV infection becomes increasingly significant when considered in conjunction with socioeconomic corollaries made previously that are associated with adolescent pregnancy. Given that the average age at high school graduation is eighteen, pregnant adolescents from higher incomes are more likely to acquire a college degree than their lower income counterparts. Disadvantaged African American adolescent females who give birth as teenagers often have a low level of educational attainment. Thus, they may have a number of socioeconomic and health challenges facing them during adolescence and into adulthood.

In addition to aforementioned problems experienced by economically disadvantaged African American adolescent females who become pregnant, they also endure higher rates of STDs. Epidemiological surveillance data on STDs among this group indicate that the rates are significantly higher when compared to white adolescent females. For example, the rates of gonorrhea among African American females ages 15 to 19 is about 10 times that of white females in the same age group. African American females also reportedly have higher rates of syphilis, with the risk of death being three times higher for African American females than for white females. Finally, rates for chlamydia are also higher among African

---

[35]Georgia Department of Human Resources, Epidemiology and Prevention Branch, HIV/AIDS in Georgia, 1994 (Atlanta, GA: Georgia Department of Human Resources, 1996) , 56-57.

[36]Georgia Department of Human Resources, Epidemiology and Prevention Branch, "Teenagers, AIDS and Sexually Transmitted Diseases in Georgia: Fact Sheet," (Atlanta: Georgia Department of Human Resources, Office of Communications, 1995) , 1.

American females than among white ones.[37] These statistics, although grim, are particularly important as they indicate the prevalence of unprotected intercourse among African American adolescent females, a behavior that places them at greater risk for unintended pregnancy and HIV infection.

TABLE 2

RACIAL DIFFERENCES IN BIRTHRATES

	Age			
Race	10-14	15-17	18-19	20-24
Black	5	84	163	165
White	.5	23	72	98
Hispanic	2	65	148	181

Source: Alan Guttmacher Institute, Sex and America's Teenagers (1994)

The main mode of HIV transmission among adolescents has been identified as unprotected heterosexual sexual intercourse.[38] Among African American adolescents, the HIV infection rate is alarmingly high, constituting 36 percent of the total AIDS cases among adolescents.[39] Some researchers have identified African American adolescents as five times

[37]Gina Wingood and Ralph DiClemente, "Cultural, Gender and Psychosocial Influences on HIV-Related Behavior of African-American Female Adolescents: Implications for the Development of Tailored Prevention Programs," Ethnicity and Disease 2 (Fall 1992) : 382.

[38]Morris, 33.

[39]Janet St. Lawrence, "African-American Adolescents' Knowledge, Health Related Attitudes, Sexual Behavior and Contraceptive Decisions: Implications for the

more likely to be diagnosed with AIDS compared to whites, while others have stated that they are eleven times more likely to contract HIV than adolescent white females.[40] AIDS is now listed as the number one cause of death for black women ages 20-44.[41] Since diagnosis with AIDS may occur as long as 15 years after infection, it is likely that many women may have become infected during their adolescent years.[42]

The number of AIDS cases that have been attributed to unprotected heterosexual sex among women has increased steadily and dramatically over the past decade. Although women represented 16 percent of all AIDS cases in the United States in 1993, the number of women who have been diagnosed with AIDS through heterosexual contact has increased 96.7 percent since 1988 among all women ages 20-29 years.

In Georgia, the AIDS epidemic among African Americans mirrors the epidemic throughout the United States. Although African Americans comprise only 29 percent of the total population in the state, the AIDS case rate is five times higher among this population than it is for whites.[43] Table 3 illustrates the number of AIDS cases by race and sex for the state of Georgia as of 1994. Interestingly, the AIDS case rate has decreased among all groups between 1990 and 1994. However, overall women account for one in four Georgians

---

Prevention of Adolescent HIV Infection," Journal of Consulting and Clinical Psychology 61 , no. 1 (1993) : 106.

[40]Ibid.

[41]Georgia Department of Human Resources, "HIV/AIDS in Georgia," (Atlanta: Department of Human Resources, Office of Communications, 1996), 2.

[42]American Red Cross, HIV/AIDS Facts Book, (Washington, DC: American Red Cross, 1995) , 16.

[43]Georgia Department of Human Resources, HIV/AIDS in Georgia, 1994, 16.

reported with AIDS in 1995, with four out of five women diagnosed in their childbearing years.[44] Although this statistic includes women of all races, it is pertinent to the current study. Given the escalating rate of infection among African American women, the percentage of cases of HIV infection has increased at such a rapid rate that they now represent 80 percent of the total number of AIDS cases among women in Georgia[45]. In reference to adolescents in Georgia, they are now identified as one of the fastest-growing groups in the state to be infected with HIV,[46] accounting for 22 percent of all the AIDS cases statewide.[47] In Georgia, the female to male ratio of AIDS cases among adolescents is four to one, with a significant amount of these cases occurring among African American females.[48]

Unprotected sexual intercourse among African American adolescent females is laden with social, economic and health consequences. Unintended pregnancy is generally accepted as a consequence that can be handled. However, one of the more severe, unrecognized consequences is infection with HIV, a potentially life-threatening disease. The conditions around which a young woman engages in behaviors that place her at risk for HIV are intricate, involving complex health behaviors and gender practices. These behaviors and the

---

[44]Ibid.

[45]Ibid.

[46]Georgia Department of Human Resources, "Teenagers, AIDS and Sexually Transmitted Diseases in Georgia: Fact Sheet," (Atlanta: Georgia Department of Human Resources, Office of Communications, 1995) , 1.

[47]Ibid.

[48]Georgia Department of Human Resources, "HIV in Georgia - An Update," (Atlanta: Georgia Department of Human Resources, Office of Communications, 1996) , 1.

factors that influence them result in a lack of one's ability to actualize and exercise one's reproductive rights. This is evidenced in attitudes about contraceptive use and the impact of gender on sexual practices.

TABLE 3

AIDS CASES IN GEORGIA BY RACE/SEX

Category	1990	1991	1992	1993	1994
Black males	676	826	963	984	690
Black females	137	202	241	243	197
White males	681	699	654	553	373
White females	42	35	42	43	34

Source: HIV/AIDS in Georgia,1994

CHAPTER 3

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Literature Review

Unintended pregnancy among adolescent females is a topic that has been investigated from a number of perspectives including the causes and consequences of this phenomenon. Studies have identified factors such as sexual behavior, social and economic conditions which may place an adolescent at greater risk for becoming pregnant. Other studies have focused on the consequences of unintended pregnancy such as poverty, low educational attainment and poor health outcomes of the mother and her child(ren). The literature also indicates that unintended pregnancy in this population serves as a marker for infection with HIV and other STDs, thus there is an increased interest in HIV and AIDS in this population. There are also a number of studies which have examined dual contraceptive use and knowledge of HIV and AIDS among adolescents. Researchers who have examined the intervening variables of gender, class and knowledge and their influence on unprotected sexual activity among African American adolescent females have not included an analysis of reproductive rights that included unintended pregnancy, contraceptive use, STDs and HIV/AIDS in this population. Furthermore, they have explained the aforementioned factors in a conventional manner, citing low socioeconomic status and lack of values as reasons for pregnancy among African American adolescent females. However, there are intervening

variables such as gender issues that inform the reproductive behavior of African American adolescent females.

This section consists of a review of the literature on sexual behavior, contraceptive use, condom use and HIV/AIDS knowledge among adolescents with a specific focus on African American adolescents. It begins with a brief overview of the patterns of sexual behavior among adolescents. Since one of the consequences of adolescent sexual behavior is unintended pregnancy, an analysis of the causes of this phenomenon is included. Section two examines current studies on contraceptive use among African American adolescent females. The third section deals with information on condom use because of the correlation between pregnancy prevention and STD prevention in this population. Some scholars have asserted that the determinants of condom use are often influenced by HIV/AIDS knowledge and gender. Therefore, a review of the literature on this aspect of condom use among adolescents is also included.

After reviewing the data and literature on the causes, direct and indirect consequences of unintended pregnancy, what emerges is a framework that suggests that there are a number of intervening variables that impact the reproductive rights of African American adolescent females. Thus, the final section is a conceptual framework which allows for the examination of the relationship between reproductive rights, unintended pregnancy and HIV/AIDS among African American adolescent females.

According to the literature, unintended pregnancy is explained by adolescent sexual behavior. Adolescence is a time when sexual behavior patterns become established. St. Lawrence (1993) notes that unprotected anal intercourse is a common sexual behavior among adolescents. This behavior poses a problem to the health of adolescents because it may

transmit HIV. However, it is often practiced because it prevents pregnancy.[1] As stated earlier, pregnancy prevention is a major concern in this age group. Practicing unprotected anal intercourse during adolescence introduces unsafe sexual behaviors that may be practiced into adulthood. Other research studies showing high rates of multiple sex partners among adolescents supports this finding. Sonenstein (1989) found that over 50 percent of adolescents had more than one sex partner.[2] Behavior patterns developed during this period of life are likely to influence whether or not contraception is used as well as the choice of contraceptive. Therefore, sexual behavior patterns developed during this time inform sexual behavior during adulthood.

Leigh et al. (1994) note that once sexual activity is initiated, adolescents continue to engage in it, although significant changes in some aspects of sexual behavior (e.g., contraceptive behavior) over time have been reported.[3] It is also known that adolescents engage in specific sexual behaviors that may place them at greater risk for unintended pregnancy and HIV infection: unprotected vaginal intercourse and unprotected anal intercourse. A study conducted by the Georgia Department of Human Resources (1994) found that 66 percent of Georgia teenagers surveyed reported being sexually active and 45

---

[1]Janet St. Lawrence, "African American Adolescents' Knowledge, Health Related Attitudes, Sexual Behavior and Contraceptive Decisions: Implications for the Prevention of Adolescent HIV Infection," Journal of Consulting and Clinical Psychology 61, no. 1 (1993) :106.

[2]Freya Sonenstein, Jospeh Pleck and Leighton Ku, "Sexual Activity, Condom Use and AIDS Awareness Among Adolescent Males," Family Planning Perspectives 21 (1989) :152.

[3]Barbara Leigh et. al. "Sexual Behavior of American Adolescents: Results from a U.S. National Survey," Journal of Adolescent Health 15 (1994) : 123.

percent had not used a condom the last time they had sex.[4] Recent studies have found that adolescents are initiating sexual activity at an earlier age than previously reported despite the threat of contracting HIV or getting pregnant.[4] Unprotected sexual intercourse, anal or vaginal, exposes sexual partners to semen, vaginal and/or other bodily fluids that may contain HIV. This fact, coupled with findings that adolescents do not regularly use condoms or other contraceptive methods consistently, result in increased rates of unintended pregnancies and STDs.

Researchers report that unintended pregnancy rates among adolescents in the United States have remained high in recent years even though there has been increased attention to the problem.[5] Although the level of awareness has been heightened, social scientists and other researchers attribute the high rates to increased sexual activity and decreased use of effective contraceptives. Furthermore, adolescent women "are at least twice as likely to have an unintended pregnancy and 3.5 times more likely to use no contraception."[6] Scholars offer several reasons that may explain high levels of unintended pregnancy among this population. The most obvious, however, is failure to use contraceptive methods correctly and

---

[4]Georgia Department of Human Resources, Epidemiology and Prevention Branch, "Teenagers, AIDS and STDs in Georgia: Fact Sheet," (Atlanta: Georgia Department of Human Resources, Office of Communications, 1995) , 1.

[4]Alan Guttmacher Institute, Sex and America's Teenagers (New York: Alan Guttmacher Institute, 1994) , 2.

[5]Laurie Schwab Zabin, Valerie Sedivy and Mark Emerson, "Subsequent Risks of Childbearing Among Adolescents with a Negative Pregnancy Test," Family Planning Perspectives, 26, no. 1 (1994) : 212.

[6]University of South Carolina, School of Public Health, Reducing Unintended Adolescent Pregnancy (Columbia, South Carolina: University of South Carolina, 1988) , 3.

consistently. Other data demonstrates that a large number of women of childbearing age were at risk for experiencing an unintended pregnancy because of lack of contraceptive use. Contraceptive use and unintended pregnancy have been found to be influenced by a number of factors including knowledge, attitudes and beliefs regarding contraception and sexual behavior patterns.

Contraceptive Use

One commonly offered explanation in the literature that seeks to explain the rising incidence of pregnancy among teenagers is their failure to select the appropriate contraceptive measures. Pregnancy prevention is the most prevalent concern of sexually active adolescents. Furthermore, for African American adolescent females and males, the highest priority in choosing a method of contraception was pregnancy prevention, followed by prevention of STDs and protection against HIV.[8] These findings support other research which demonstrates that pregnancy prevention is often viewed as more important than disease prevention among sexually active adolescents.[9] Kahn (1990) reports that younger

[8]St. Lawrence, 109.

[9]Joan Kahn, Ronald Rindfuss and David Guilkey, "Adolescent Contraceptive Method Choices," Demography 27, no. 3 (August 1990) : 323-335.

adolescents may opt for over-the-counter methods such as condoms, spermicide and foam whereas older ones may use family planning services to obtain oral contraceptives.[10]

Other research on contraceptive use among adolescent females has shown that they are generally more knowledgeable about contraceptive methods than males, although males are more likely to rely on a condom. For all adolescents, condoms are the primary method of contraception early on in their sexual careers.[11] Other studies support similar findings, reporting high rates of male condom use among adolescents during their first sexual experience.[12]

Research conducted by the Alan Guttmacher Institute (AGI) indicates that the most frequent use of condoms is among teenagers who are white or from higher income level families.[13] Researchers investigating condom use among adolescents reported that more males than females use condoms; males are more knowledgeable on correct condom use and more likely to know that condoms prevent STDs than females.[14] Interestingly, research by Kegeles (1990) found that males were more likely to intend to use a condom, and they also

---

[10]Ibid., 324.

[11]Vaughan Rickert et. al. "Adolescents and AIDS: Female's Attitudes and Behaviors Toward Condom Purchase and Use," Journal of Adolescent Health Care, 10 (1989), 313.

[12]Michele Wilson et. al. "Attitudes, Knowledge and Behavior Regarding Condom Use in Urban Black Adolescent Males," Adolescence 29:113 (Spring 1994), 14.

[13]Alan Guttmacher Institute, 34.

[14]Nancy Leland and Richard Barth, "Gender Differences in Knowledge, Intentions, and Behaviors Concerning Pregnancy and Sexually Transmitted Disease Prevention Among Adolescents," Journal of Adolescent Health 13 (1992) : 598.

perceived their partner to be in accord with their decision.[15] These findings demonstrate that each gender chooses contraceptive methods within their locus of control.

Scholars also argue that age influences contraceptive method choice. Condom use reportedly decreases as adolescents get older. As sexually active adolescents move into adulthood, they use more reliable, long- term contraceptives such as oral contraceptive pills, Depo Provera or Norplant.[16] According to Leland and Barth, older adolescents choose methods that are more effective, such as oral contraceptive pills, hormonal implants or injections.[17]

Galavotti and Schnell (1994) report that there is a decreased perceived risk of HIV infection and a higher level of self-confidence in the ability to prevent HIV infection among women who used oral contraceptives consistently compared to women who used condoms consistently as their sole method of contraception.[18] These researchers argue that, "Women's beliefs about the effectiveness of a method for pregnancy prevention may apply to beliefs about the method's efficacy for disease prevention."[19] This suggests that some women may believe that oral contraceptives provide effective protection against HIV and pregnancy and that condoms are not an effective method for either. Furthermore, according to these

---

[15]Susan Kegeles, Nancy Adler and Charles Irwin, "Sexually Active Adolescents and Condoms: Changes Over One Year in Knowledge, Attitudes and Use," American Journal of Public Health 78 (1990) , 460-461.

[16]Alan Guttmacher Institute, 34.

[17]Leland, 596.

[18]Christine Galavotti and Daniel Schnell, "Relationship between Contraceptive Method Choice and Beliefs about HIV and Pregnancy Prevention," Sexually Transmitted Diseases 21, no. 1 (1994) : 5-7.

[19]Ibid.,7.

researchers, methods which provide low levels of user compliance, such as Depo Provera and Norplant, and have higher rates of proven effectiveness at preventing pregnancy are preferred since pregnancy prevention is the main objective. Thus, these methods are perceived as the most effective against disease prevention[20]. Consequently, methods that offer low levels of user responsibility and have higher rates of proven effectiveness at preventing pregnancy are preferred by women.

Since the recent approval and subsequent release of Norplant and Depo Provera by the Food and Drug Administration (FDA), the rate of long-term contraceptive use has increased among adolescents. Because pregnancy prevention is of the utmost concern and long term contraceptives such as Norplant and Depo Provera are the most effective contraceptive choices to achieve this goal, their use is advocated by health care providers. However, these methods do not provide protection against STDs, particularly HIV.

Since adolescents, as a group, are at greater risk for HIV infection and other STDs, there has been an increased interest among public health scientists, physicians and other health care providers to advocate for condom use in addition to the use of long-term contraceptive methods as a means to prevent unintended pregnancy and contracting a STD. However, research by Kahn et al. (1990) indicates that overall, condom use is low among adolescents, including those who use other forms of contraception in addition to condoms.[21]

Numerous researchers report that consistent use of long-term contraceptives have, in fact, reduced consistent use of condoms. Frank (1992) found that for women who used Norplant, 43 percent reported regularly using condoms and 52 percent reported rarely or

---

[20]Ibid., 6.

[21]Kahn, 327.

never using condoms. The larger group self-reported that the implants protected them from pregnancy, a more prevalent concern. Overall, 21 percent of the sample population reported that they would stop using condoms since they used a reliable method of birth control.[22] These findings suggest that long- term contraceptive users rely on condoms for pregnancy prevention in the early stages of a sexual relationship, however, they do not perceive themselves at risk for acquiring a STD and therefore, do not practice life-saving behaviors.

Humphries and Bauman (1994) investigated condom use among Norplant users and found that 58 percent of the sample used condoms all the time, 16 percent some of the time and 26 percent reported never using condoms. Furthermore, 42 percent of the respondents were at greater risk for STDs and 38 percent of those at risk did not use condoms at all.[23] Frank stated that 42 percent of Norplant users reported using condoms prior to receiving Norplant, and almost half of those who had used condoms no longer elected to do so after receiving the implants.[24] A study by Detzer (1995) concluded that fear of pregnancy, not STDs, is the primary motivation for using condoms and that condom use decreases with reliance on oral contraceptives.[25] An investigation into the level of condom use among adolescents who used oral contraceptives found that 30 percent of the sample engaged in sexual behaviors that placed them at greater risk for acquiring an STD, and 16 percent of the

---

[22]Margaret Frank et. al. "Characteristics and Attitudes of Early Contraceptive Implant Acceptors in Texas," Family Planning Perspectives 24 (1992) : 229.

[23]Helen O. Humphries and Karl E. Bauman, "Condom Use by Norplant Users at Risk for Sexually Transmitted Diseases," Sexually Transmitted Diseases (July/August 1994) : 217.

[24]Frank, 212.

[25]Mark Detzer et. al. "Barriers to Condom Use Among Women Attending Planned Parenthood Clinics," Women and Health 23, no. 1 (1995) :100.

30 percent reported using condoms. Furthermore, those who used condoms self-reported that they used them primarily to prevent pregnancy.[26] These findings support previous research which found that pregnancy prevention is the primary reason for contraceptive use, regardless of prior history of infection with or risk of contracting a STD.

Investigators have also found that although there was a strong intention to use condoms and that AIDS had influenced the decision of adolescent females to purchase a condom, only 10 percent reported using a condom and oral contraceptives to effectively prevent pregnancy and infection with HIV.[27] Although these studies have examined this complex issue from a unilateral and/or a multidimensional perspective of knowledge, attitudes, practices and behavior, there are additional factors that can be included in developing an understanding of reproductive health of African American adolescent females and their partners.

Level of HIV/AIDS Knowledge

The high rates of HIV infection among this population has not only been explained by investigators in terms of sexual activity but also by the level of HIV/AIDS knowledge. Numerous studies that investigated the baseline AIDS knowledge level of adolescents found that in general, adolescents demonstrate a general increase in knowledge, with older students

---

[26]Carole Weissman et. al. "Consistency of Condom Use for Disease Prevention Among Adolescent Users of Oral Contraceptives," Family Planning Perspectives 23 (1991) : 73.

[27]Rickert, 315.

demonstrating higher levels of knowledge.[28] However, these surveys also indicated that there were large gaps in knowledge about HIV transmission and prevention. Respondents answered questions about transmission and prevention incorrectly most frequently. For example, a study conducted in 1987 by Strunin and Hingson (1990) reported that students were largely misinformed or confused about AIDS and had little understanding of the modes of transmission. The telephone survey consisted of 860 students ages 16 to 19 years old. The investigators found that the majority of the study population answered less than 20 percent of the questions related to HIV/AIDS knowledge correctly even though many of the respondents self-reported practicing preventive behaviors .[29] The findings stated that knowledge did not influence behavior.[30] DiClemente et. al. (1991) reported higher levels of knowledge but found information gaps, with results demonstrating that although 92 percent of the sample knew that the main mode of HIV transmission was unprotected sexual intercourse, only 60 percent knew that using a condom reduced the risk of transmission.[31]

Other investigators have found that the level of HIV knowledge does result in preventive behavior. They contend that adolescents are misinformed or confused about transmission and prevention.[32] Still other researchers have found that adolescents who place

---

[28]Ralph DiClemente et. al. "Comparison of AIDS Knowledge and HIV-Related Sexual Risk Behaviors Among Adolescents in Low and High Risk AIDS Prevalence Communities," Journal of Adolescent Health 14 (1991) : 231.

[29]Strunin, 26.

[30]Lee Strunin, Ralph Hingson and Beth Berlin, "AIDS Transmission: Changes in Knowledge and Behaviors Among Adolescents, 1986-1988," *Pediatrics* 85:(1990), 312.

[31]DiClemente, 235.

[32]DiClemente, 234.

themselves at greatest risk have a lower level of HIV/AIDS knowledge and report lower condom use than their peers.[33] Contrary to the latter findings, Brown(1992) found that consistent condom users had greater intentions to use condoms, and believed that condoms provided effective prevention against HIV, however, there was no significant difference between consistent and inconsistent users on HIV knowledge.[34] Investigators explain the absence of behavior change or lack of condom use regardless of having information on how to do so by the inability of adolescents to understand how HIV prevention information can be implemented in their lives to promote and maintain life saving behaviors.[35] Given the fact that unintended pregnancy indicates unprotected sexual intercourse, adolescents are not practicing behaviors that they know can place them at risk for HIV infection. This clearly illustrates a disparity between knowledge and condom use and thus, supports the statement that adolescents are at an increased risk for HIV infection because of their sexual practices.

Research on the differences in knowledge between genders and races among adolescents has also been conducted. Findings in this area indicated that there are not significant race differences, but gender differences are demonstrated. St. Lawrence (1993) noted that female adolescents were more knowledgeable about AIDS than their male counterparts.[36] Stevenson (1995) found that not only did female adolescents demonstrate

---

[33]Sonnenstein, 157.

[34]Larry Brown, Ralph DiClemente and Teron Park, "Predictors of Condom Use in Sexually Active Adolescents," Journal of Adolescent Health 13 (1992) : 658.

[35]Jay Fleisher et. al. "Condom Use Relative Knowledge of Sexually Transmitted Disease Prevention, Method of Birth Control and Past or Present Infection," Journal of Community Health 19, no. 6 (1994) : 395-407.

[36]St. Lawrence, 10.

a higher level of knowledge, but that they also had a "stronger tendency to endorse beliefs that they could apply protective behaviors within high risk situations."[37] St. Lawrence also found that overall, African American adolescents are knowledgeable on how to prevent the spread of HIV, however, they did not practice preventive behaviors during sexual intercourse that may prevent the spread of HIV.[38] In addition, while knowledge levels may not be different between races, knowledge is related to behavior. Inherent in St. Lawrence's research is the suggestion is that there are other intervening factors related to the lack of condom use, such as male control over actual condom use.

Investigators have concluded that gender may explain or influence contraceptive use, and therefore, contribute to the increasing incidence of unintended pregnancy among adolescents.[39] Since women of childbearing age most often bear the burden of unintended pregnancy and preventing pregnancy is a priority for them, they have been traditionally responsible for contraception. Frequently, contraceptive choices of women are methods that

---

[37]Howard C. Stevenson et. al. "HIV Prevention Beliefs Among Urban African-American Youth," Journal of Adolescent Health 16, no. 4 (1995) : 319.

[38]Arlene Rubin Stiffman, Peter Dore and Renee M. Cunningham, "Inner-City Youths and Condom Use, Health Beliefs, Clinic Care, Welfare and the HIV Epidemic," Adolescence 29 , no. 116 (Winter 1994) : 806.

[39]St. Lawrence, 108.

are female-controlled[40] and the most effective pregnancy prevention methods are female-controlled.

Zelnick and Kantner (1980) concluded that among women who used contraception at first intercourse, condoms were their contraceptive choice.[41] Studies that have looked at contraceptive choices among males have found that during early sexual experiences condoms were also chosen.[42] Other studies have found that the partners of sexually active adolescent women contribute to decisions regarding sexual activity and contraception.[43] These findings indicate the difference in perception of who controls condom use - males or females. The data also suggest that while condom use may be gender-related, condom use can be controlled by either gender. Furthermore, as St. Lawrence suggests, each gender may opt for methods within their control.[44]

The intersection of gender into contraceptive practices has yielded interesting findings. The belief that condoms are a male-controlled[45] method serves as a barrier to condom use among women. Plichta et. al. (1992) found that women are embarrassed to

---

[40]See "Definitions" section.

[41]Melvin Zelnick and Joseph Kantner, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan Area Teenagers: 1971-1979," Family Planning Perspectives 12 (1980) : 235.

[42]Melvin Zelnick and Farida Shah, "First Intercourse Among Young Americans," Family Planning Perspectives 15 (1983) : 66.

[43]Laurie Zabin and Samuel Clark, "Why They Delay: A Study of Teenage Family Planning Clinic Patients," Family Planning Perspectives 13 (1981) : 215.

[44]St. Lawrence, 109.

[45]See "Definitions" section.

discuss condoms fearing rejection by their partner and thus, are not likely to use them. [46] On the other hand, Pleck (1994) stated that women play an important role in determining whether or not their male partners will use a condom, reporting that the attitude of the male partner was also found to have a significant impact on condom use.[47] Overall, researchers have found that if the woman's partner was supportive of condom use, the probability of consistent condom use increased.[48]

Kegeles et. al. (1989) found that female adolescents were more likely to have their partners use condoms because "using condoms requires that the partner use self-control."[49] This suggests that some young women may not view condoms as a male-controlled method and that adolescent women desire to have their partners participate in contraception. Similarly, Fleisher (1994) found that condom use among women was more likely if the male partners were supportive of condoms.[50] Interestingly, Kegeles et. al. concluded that male adolescents accept the responsibility for contraception which, they concluded, may be indicative of their desire to participate in contraceptive-decision making.[51] In contrast, Wilson found that although African American adolescent males had a desire to prevent

---

[46]Plichta, 508.

[47]Pleck, 210.

[48]Fleisher, 398.

[49]Susan Kegeles, Nancy Adler and Charles Irwin, "Adolescents and Condoms: Associations with Beliefs of Intentions to Use," American Journal of Disease of Children 143 (August 1989) : 914.

[50]Fleisher, 406.

[51]Ibid.

STDs, having an STD or having impregnated a woman did not mandate condom use.[52] The investigators in this study stated that condom use among males was associated with STD prevention more so than pregnancy prevention.

Gender

Due to the fact that unintended pregnancy is most frequently a result of a lack of contraceptive use, an examination of the role that gender plays in reproductive behavior is important. Throughout the literature it seems that gender often is an intervening variable when investigating contraceptive use, especially condom use. Other factors that have been found to influence condom use among both adolescent and adult females and males have been identified as: length of the relationship, regardless of frequency of intercourse and the use of other methods of contraception.

Plichta et. al. (1992) investigated the rate of condom use among adolescent women and their partners as it related to personal attributes, intensity of the relationship and communication between the partners. This investigation concluded that adolescent women were no more likely to use a condom consistently with non-exclusive partners than with exclusive ones.[53] However, an important determinant of condom use was the length of the relationship with a given partner regardless of the sexual history of the partner, frequency of intercourse and use of oral contraceptives. These findings suggest that adolescent women are more likely to use condoms in the early stages of their relationship with a new partner but

---

[52]Wilson, 23.

[53]Stacy Plichta et. al. "Partner-Specific Condom Use Among Adolescent Clients of a Family Planning Clinic," Journal of Adolescent Health 13 (1992) : 510.

discontinue use over the course of the relationship. This may also suggest that as the length of a relationship increases, the perceived risk of STDs may decrease. Brown et. al. reports consistency of condom use was correlated with intention to use condoms, gender and past sexual activity, stating that males are more likely to use condoms consistently than females.[54]

Rates of condom use are reportedly higher among adolescent males than females. Researchers have acknowledged that the role of condom decision-making is often within the scope of male power.[55] This can be interpreted as "males control condom use," even though contraception is often viewed as the responsibility of the female. It is important to note that the rate of male-to-female HIV transmission is higher than rates of female-to-male. Therefore, the danger to females is greater, thereby increasing the need to use condoms in order to prevent HIV infection and unintended pregnancy.

Scholars view pregnancy prevention as an important issue in the well-being of adolescents. However, the issue of maintaining one's reproductive health, particularly, preventing the spread of HIV among adolescents is germane because HIV is a life-threatening, chronic illness. Research has shown that there are a number of factors that prevent condoms from being used during sexual intercourse, including findings that suggest that there is a gendered perception of contraceptives. This plays a major role in determining whether or not preventive measures against potential HIV infection will be taken.[56]

---

[54]Brown, 655.

[55]Leigh, 124.

[56]St. Lawrence, 112.

Throughout the literature, pregnancy prevention is documented as the primary concern of women, including adolescents. Methods that most effectively prevent pregnancy such as Norplant, Depo Provera and oral contraceptives are preferred to condoms, a method that is perceived as less effective. While most agree that reducing the rate of teenage pregnancy is important, the ways in which this is most effectively achieved do not protect the user or her/his partner from acquiring a STD, particularly HIV. Although public health professionals have noted this and have expanded prevention education efforts to include condom use in addition to other forms of contraception, there is still a gap in knowledge, education and actual practice by the contraceptive user which is demonstrated in the increasing rate of HIV infection among adolescents.

Furthermore, since researchers interpret the application of non-barrier methods as being within the locus of control and ultimately the responsibility of the female, they assume that the use and selection of non-barrier methods are female-controlled. By the same token, there is a perception that the method within the scope of control of the male, the condom, as male-controlled. There has been a considerable amount of research on unintended pregnancy, HIV/AIDS and contraceptive use among adolescent females. Studies have shown that knowledge about preventing HIV transmission may or may not inform condom use.[57] Other researchers have documented that there are a number of barriers to condom use among adolescents, both male and female, who have some level of knowledge about how to

---

[57]Arlene Stiffman, Peter Dore and Renee Cunningham, "Inner-City Youths and Condom Use: Health Beliefs, Clinic Care, Welfare, and the HIV Epidemic," Adolescence 29 , no. 116 (1994) : 816.

protect themselves from HIV.[58] Therefore, one can assume that there is a relationship between knowledge, practice and gender.

According to Stevenson, the level of HIV prevention knowledge among adolescent females is higher than that of males.[59] However, the rate of HIV transmission in women has increased significantly compared to that of males. In addition, the perception of AIDS risk has shown to be higher among females than among males which may be related to higher levels of AIDS knowledge. Overall, adolescents have acquired the knowledge that will prevent them from becoming infected with HIV and that in many cases, young women believe they can and will practice behaviors that will reduce their risk of HIV. However, in application, a condom is often not used. This intimates that there are a multitude of factors, including gender, that impact health related behaviors. Even though gender differences in knowledge are consistent across the board, this does not explain the void between practice and knowledge. Thus, a study that examines the reproductive rights issues of African American adolescents as they relate to contraceptive use is essential to decreasing the rate of HIV infection in this population.

Conceptual Framework

The research and analysis in this study examines the reproductive rights issues of African American adolescent females who are at risk for HIV because of contraceptive use

---

[58]Joseph Pleck, Freya Sonenstein and Leighton Ku, "Adolescent Males' Condom Use: Relationships between Perceived Cost-Benefits and Consistency," Journal of Marriage and Family 53 (1991) : 744.

[59]Stevenson, 320.

or a lack thereof. Since the major health problems of adolescents are related to sexuality, research related to unintended pregnancy and STD infection are used to examine this topic.

Unintended teenage pregnancy may contribute to health, social and economic difficulties for adolescents. As mentioned previously, research shows that adolescents who have children at an early age increase their risk for maternal morbidity, infant mortality, low levels of educational attainment and/or poverty. These obstacles may impact the development of the adolescent, including health. Therefore, an essential component of the solution to addressing these social issues and ultimately improving the health of African American adolescents, particularly females, is to decrease the rate of unintended pregnancy in this group.

Since females are biologically equipped to bear children, the focus on preventing pregnancy often centers around females. Adolescent females are perceived as being at higher risk for unintended pregnancy because of a demonstrated inability to consistently use other effective contraceptive methods. Another contributing factor, as it relates to African American adolescent females, is the perception of the sexuality of black women.

Sex-role socialization is influenced by race, class and culture and is a developmental trait that is established early in life. Wingood et al. note that sex-role socialization differs in the African American community from the white community with the gender role socialization for African American adolescent females tending "to emphasize adult responsibilities...that develop a sense of competency and independence."[60] Thus, if young African American females are socialized on an adult level in one sense but lack the sexual expertise that would allow for issues such as condom negotiation between partners, their

---

[60]Wingood and DiClemente, 383.

socialization may result in an inability to practice health-promotion behaviors, including condom use.[61] Because this pattern is established early in one's sexual career, not being able to exercise behaviors that prevent pregnancy and infection with HIV because of the influence of gender on behavior may be perpetuated throughout life. However, societal inequalities also contribute significantly to this analysis.

For African American adolescents, interactions with health care providers and/or their partners may result in feelings of powerlessness or a perceived lack of control over their bodies. With regards to HIV, this contributes to the increased risk of infection for African American adolescent females in that their life circumstances may place them in situations where there is little or no control over using health behaviors that may prevent infection with a STD, including HIV. Research by Stevenson et al. echoes this observation. Stevenson (1995) found that there was no significant gender difference in HIV prevention knowledge among African American adolescents, although African American males were more likely to believe that they could actually carry out safe sex behaviors whereas females did not exhibit the same belief.[62]

When looking at the issue of how knowledge and non-barrier contraceptives impact condom use among African American adolescent females, what emerges is a framework that suggests there is a relationship between knowledge, gender and contraceptive use, factors that have been considered in the literature as an integrative whole. Scholars tend to support the proposed hypothesis that this relationship and contraceptive practices are filtered through

---

[61]Ibid.

[62]Stevenson, 320.

the dynamic of what we refer to as the "gendered division of contraceptives."[63] Additionally, the scope of a gendered division of contraception intimates that power impacts reproductive behavior, particularly condom use, thus having an effect on the reproductive rights of African American adolescent females. Research by Guttmacher et. al. (1995) supports this concept, noting that 22 percent of sexually active adolescent females stated that they had been in situations in which they wanted to use a condom and their partners did not.[64] Forty two percent of those self-reported that they had engaged in unprotected sex when faced with this situation. On the other hand, only 16 percent of the sexually-active male adolescents reported the same dilemma.[65] This further demonstrates the contrast between attitudes and practice between young women and their sexual partners. Findings by Guttmacher et al. also illustrate a trade-off of the right to control a critical aspect of their reproductive behavior, despite their young age. This dynamic is also present in women who use contraceptive methods that are perceived to be female-controlled.

Historically, public policy officials and health care providers have advocated that the use of Norplant, Depo Provera and oral contraceptives empowers women since they are female-controlled. While providing low-maintenance options for women and a higher level of effectiveness at preventing pregnancy, these methods may increase the risk of exposure

---

[63]See Definitions section for further explanation.

[64]Sally Guttmacher et. al. "Gender Differences in Attitudes and Use of Condom Availability Programs among Sexually Active Students in New York City Public High Schools," Journal of the American Medical Women's Association 50, 3&4 (1995) : 105.

[65]Ibid. 101.

to HIV because they are non-barrier methods. That is, they do not provide protection against acquiring a STD.

The introduction of Norplant and Depo Provera as contraceptive options has added another element to the complex puzzle of condom use among adolescent females. The reportedly high rates of unintended pregnancies among African American adolescent females as well as documentation that they begin sexual activity at an earlier age than white females have led some to believe that the reproductive behavior of African American adolescent females needs to be controlled. Before the introduction of these new contraceptive technologies, adolescents who wanted to prevent pregnancy used oral contraceptive pills. However, unintended pregnancy rates did not decrease significantly and studies demonstrated low levels of consistent use among adolescents. Recent efforts aimed at reducing the unintended pregnancy rate of adolescents have centered around the use of long-acting hormonal contraceptive methods such as Norplant and Depo Provera. Studies that have investigated the use of these methods among adolescents have found that many of the users have used oral contraceptive pills previously and have had one pregnancy, supporting the notion that adolescent females display irresponsible reproductive behavior.

Most supporters of the use of Norplant and Depo Provera in adolescent populations agree that reducing the unintended pregnancy rate of African American adolescent females would improve their life chances and that additional contraceptive technologies would increase the reproductive choices of women. However, the involvement of the government, medical establishment and other organizations in the reproductive behavior of African American females raises questions. Historically, governmental involvement in the medical care of African Americans in the United States has resulted in blatant abuse, including racial

and sexual discrimination (e.g., Tuskegee Study, forced sterilization). While the introduction of these methods is intended to improve the reproductive health of women, including adolescents, and increase their level of reproductive control, it does not achieve this goal for all women of childbearing age. For some women, the risks from side effects of Norplant such as irregular menstrual cycles, uterine bleeding, headaches, significant changes in weight, fluid retention and depression may outweigh its use as a contraceptive method.

In addition, since this particular method provides protection against pregnancy for up to five years, it is also possible to conceive that it may place the reproductive health of the user in further jeopardy since Norplant users do not have to return for follow-up visits on a regular basis, unlike contraceptive pills or Depo Provera. Thus, Norplant acceptors may not receive preventive reproductive health care services (Pap smears, STD screening), thereby possibly placing them at an increased risk for reproductive health problems, such as HIV infection.

Researchers have found low levels of knowledge about Norplant among adolescent users.[66] This suggests that health care providers may influence contraceptive method choices without patient's having information about the side effects and other related concerns, thus raising concerns about informed consent and informed choice. Unfortunately, although long-term contraceptives may present themselves as a more effective method to prevent pregnancy than condom use, they will not prevent a sexually active adolescent from contracting a STD. These long-acting hormonal methods are expensive and users often receive family planning services through publicly funded clinics. Thus, those most likely to be affected by their use

---

[66]Karen Kozlowski et. al. "Knowledge and Attitudes of Norplant Among Adolescent Females," Adolescent Pediatric Gynecology 7 (1994) : 71.

are low-income African American females, those who are also at greatest risk for unintended pregnancy. In fact, these methods appear to target one group of women, low-income, African American females, who may be teens.

Long term contraceptive use does not address the root causes of unintended pregnancy among African American adolescent females, nor the interrelated issues of poverty, health and social conditions that may predispose them to unintended pregnancy. Instead, the methods essentially appear to control social behavior and fertility of a group that is least able to assert their reproductive rights and at the same time, jeopardizes the health of the user.

In support of the argument for hormonal methods such as Norplant and Depo Provera, advocates posit that these methods afford women the opportunity to exercise reproductive control, a relatively new concept in the sphere of women's health and human rights. For centuries, women have operated under the view that autonomy over their bodies, fertility and health is within their locus of control. This concept is rooted in the abortion rights campaigns of the 1970s as white feminist activists struggled to defend the rights of women to safe, legal abortion and funding in the United States and Europe. In the 1980s, the promotion of reproductive rights as a fundamental principle for improving the status of women was championed by women's rights activists at the United Nations Decade of Women Conference in Nairobi.

Interestingly, although the concept of reproductive rights refers to empowerment for women, regardless of race, age, income or religion, specific reproductive rights issues and strategies may vary among races, age groups, income levels and religion. In addition, comprehensive reproductive health, which is the underlying principle of reproductive rights,

as well as priorities to achieve this goal, may also be defined according to the needs of the targeted group. For instance, in developing countries, the priority for women's reproductive health may be identified as decreasing the maternal morbidity rate, while in countries such as the United States, a priority for achieving adolescent reproductive health might be decreasing the rate of unintended pregnancy.

One of the primary issues of those concerned with women's reproductive rights is that of the lack of political power by women to persuade policy makers to protect and promote women's reproductive health.[67] An example of this can be observed in the debate around population and contraception. Women's health advocates in countries of the north and south have been torn on the issue of birth control. The right to control fertility through the use of contraception is seen as "an individual, autonomous act of empowerment."[68] However, as Dixon-Mueller notes, this concept has been hindered by the demographically-driven and politically-driven policies aimed at population control, specifically through family planning programs. As a result, groups such as the medical establishment that could serve as advocates in the struggle to achieve good health for women, become allies for policy makers and researchers whose aim is to achieve their own political and scientific goals.[69] In the United States, the use of Norplant by adolescents serves as a classic example of the

---

[67]Rebecca Cook and Mercedes Plata, "Women's Reproductive Rights," International Journal of Gynecology and Obstetrics 46 (1994) : 215.

[68]Ruth Dixon-Mueller, Population Policy and Women's Rights: Transforming Reproductive Choice, (Westport, CT: Praeger Publishing Co., 1993) , 33.

[69]Ibid.

debate between advocates for women's reproductive rights, the medical establishment and the government.

The approval of Norplant in 1990 by the Food and Drug Administration (FDA), resulted in mixed feelings about its introduction as a contraceptive option for women. Although some women's health advocates initially viewed the introduction of long-acting contraceptives as a victory in the struggle for female-controlled methods, it was eventually greeted with intense debate in political and social circles. Shortly after its introduction, an editorial in the Philadelphia Inquirer stated that if Norplant were targeted to African American women or other groups of low-income women, it could help reduce expenditures on public assistance.[70]

Viewpoints such as these fuel the belief that Norplant and other long-acting contraceptives can be used as tools in the fight against social problems such as poverty and unintended teenage pregnancies. This also contributes to the paradox between reproductive control and reproductive rights and the larger debate between rights activists and other stakeholder groups. In this arena, reproductive rights becomes an oxymoronic term, particularly for African American women, who are often the targets of public policy related to fertility control and other measures aimed at achieving some sense of social control. An example of this is demonstrated in the number of African American women who use

---

[70]"Can Contraception Reduce the Underclass?" Philadelphia Inquirer, 12 December 1990.

Norplant. In 1992, 65 percent of the 1,100 Norplant acceptors were African American women.[71]

In defense of this fact, health care providers argue that because the cost for insertion is expensive, often reported as high as $1,000, many private health care providers do not offer the procedure. However, Norplant and Depo Provera have been made available specifically to poor women through Medicaid, thus making it easier for them than for any other group to have access to these forms of birth control.[72] Alexander Cockburn notes that nine out of ten Norplant insertions were paid for through Medicaid coverage.[73] For those women not already covered by Medicaid, the Norplant Foundation was established with the assistance of a $2.8 million grant from Wyeth-Aherst, the manufacturers of the drug. This foundation was developed to provide financial assistance to women who choose Norplant.

Furthermore, Norplant, in particular, has received widespread support since its approval by politicians, courts and legislatures as a condition of welfare benefits. In the first year it was approved, twenty legislative measures seeking to make use of Norplant mandatory for women who receive public assistance were introduced in thirteen state legislatures. Additionally, thirteen states proposed legislation that would pay AFDC mothers a significant incentive to have Norplant inserted and to leave it in for the recommended five

---

[71]Winslow Mason, Jr. "Norplant Linked to Women of Color," The Philadelphia Tribune, sec 1A, p.2

[72]Alexander Cockburn, "Norplant and Social Cleansers," The Nation 259, no. 4 (1994) : 116 - 117.

[73]Ibid.

year period.[74] Other legislative measures aimed at achieving reproductive control have been requiring women who are convicted of child abuse or child neglect to have Norplant inserted.

The gender discrepancy in the endorsement of this form of reproductive control is clear. Poor men who father children are not legally prevented from having children. Although one could argue that there are no reversible methods of contraception for men, the fact that men are not held accountable for their reproductive actions, specifically once children are born (as evidenced by the weak enforcement of child support legislation) negates this argument. In addition to the gender discrepancy, the racial undertones of its advocacy are well-pronounced.

African American women are often seen as transmission belts that drive the cycle of poverty. Therefore, efforts to control their fertility are vital to achieving some level of societal control and reducing the rate of poverty. However, some scholars argue that teenage pregnancy may not result in poverty, but that the disadvantaged backgrounds of the mother herself maybe more of a factor.[75] If this is the case, teenage pregnancy prevention programs and public policy that seeks to reduce unintended pregnancy rates among teens will, in reality, do little to improve the life chances of the mother and her child.

Also inherent in the advocacy of Norplant and Depo Provera is the patriarchal belief that the state has the right to control women's bodies through regulating the reproductive behavior of women it supports. This belief also assumes that the recipient has a responsibility to the system that supports her and her family. The theoretical underpinning of this argument is that long-acting methods offer a viable choice for women who want to

---

[74]USA Today, Editorial, 16 February 1993, 10.

[75]Klepinger, 23.

control their fertility. However, the irony in all of this is that use of these methods are not, in fact, controlled by women.

Feringa et al argue that there is an inverse relationship between user compliance and method efficacy. That is, the greater the amount of motivation and power required of the user, the less effective the method is, therefore increasing chances for coercive use.[76] For example, Norplant must be inserted and removed by a trained health care provider, thus causing the user to become dependent on the ethics and motivation of the health care provider. There have been numerous reports of women being forced or coerced into having the implants inserted. In other cases, after experiencing complications as a result of using Norplant, women have requested to have the implants removed and their requests denied, particularly if the recipient is the head of her household, receives public assistance and has more than one child.

Another example of possible coercive use is in legislation which provides incentives for women who use Norplant for the recommended five year period. Coercion is also evidenced in findings of user-compliance studies that found that doctors assume low-income women are incapable of effectively using oral contraceptives, a method that requires a high level of user responsibility. In this scenario, a health care provider may consciously or unconsciously violate principles of informed consent by not offering the recipient information on all available birth control methods, including their possible risks. These public health practices do not reflect individual control over one's right to reproduce.

---

[76]Barbara Feringa, Sarah Iden and Allan Rosenfeld, "Norplant: Potential for Coercion," in Norplant and Poor Women, ed. Sarah Samuels and Mark Smith (Menlo Park, CA: Kaiser Foundation, 1992) , 58-59.

Unfortunately, reproductive rights seems null and void, particularly for African American women.

Gender also contributes to this equation because of its important role in issues of control throughout societies. Dixon-Mueller states, "Inequalities based on gender pervade every aspect of social life and affect girls' and women's chances for survival and security in fundamental ways."[77] Corrêa and Reichmann note that gender subordination places women in situations in which their partners will not use condoms.[78] For women who use long-term contraceptives , the impact of gender on dual contraceptive use is of particular importance. While using a non-barrier contraceptive method may give women a greater locus of control over preventing unintended pregnancies, women may not have control over whether or not a condom is used.

For adolescents, long-term contraceptives may allow protection against pregnancy, however, protection against contracting HIV may not be a situation in which she has the ability to demonstrate reproductive control. Male domination may control a situation, causing the female partner to become insubordinate. Thus, the issue of gender, preventing unintended pregnancy and HIV are important in that it relates to a woman's desire to exercise her reproductive rights and to establish reproductive autonomy.

Unintended pregnancy among African American adolescents concerns public health specialists, policy makers and society at large. There are a multitude of reasons for this concern, such as: increased life chances, decreased poverty levels and improved health status.

---

[77]Ibid., 8.

[78]Sonia Corrêa and Rebecca Reichmann, Population and Reproductive Rights: Feminist Perspectives from the South (London: Zed Books, 1994) , 75.

Decreased unintended pregnancy rates among African American adolescents could improve the health of children and the health of the mother. Specifically, maternal health would improve if condoms are used to prevent STD infection. However, because the reproductive behavior of these women is used as a scapegoat to explain poverty, there is a perceived need to control this behavior. This manifests in the development and support of contraceptive technologies that require little user responsibility, thus, placing the user in a powerless position with regards to controlling reproductive behavior and her rights. In addition, for sexually active women, the only way to prevent acquiring a STD is to use a condom. However, this is most often controlled by men. Again, the adolescent female is placed in a powerless position and cannot exercise her fundamental right to maintain her reproductive health.

In order to empower women to implement the right to individual control over one's reproduction, it is necessary to deconstruct the existing paradigm of a gendered division of contraceptives, including use and distribution. Empowerment will facilitate one's ability to reproductive control - not only in regards to preventing unintended pregnancy but also in regards to preventing infection with HIV.

Research Design

Georgia has the eighth highest AIDS case rate and highest teenage pregnancy rate in the United States. Of particular note are statistics from the metropolitan Atlanta area which show some of the highest rates of STDs and teenage pregnancy rates in the state.[79] Atlanta

---

[79]Georgia Department of Human Resources, Epidemiology and Prevention Branch, HIV/AIDS in Georgia 1994, (Atlanta, GA) 1996, 5, 57.

was selected as the site of this study because of the prevalence of markers for HIV infection such as unintended pregnancies and STDs.

This study investigates the relationship between AIDS knowledge, HIV prevention and contraceptive use among African American adolescent females. These components inform reproductive behavior. The research design employed both qualitative and quantitative methods of data collection and analysis. Qualitative data collection methods included focus groups with participants in community-based programs.

A pilot test of the survey instrument and the focus group guide was completed in December, 1995 (N=23). As a result of this exercise, a number of items were omitted, revised and/or clarified on the survey instrument. Questions regarding casual contact were added to the section that measured HIV/AIDS knowledge. Questions that inquired about the status of the respondents' health and socioeconomic status (e.g. previous STD infection, and side effects from contraceptives, household income) were omitted. Other questions were restructured and instructions to choose only one response were included. Revisions to the focus group guide included the addition of two scenarios in order to acquire information about the impact of gender on the research topic.

The researcher met with administrators from the West End Medical Centers (WEMC) and the Center for Black Women's Wellness. During the meeting, the researcher explained the focus of the research, methodology and asked for assistance in recruiting participants. A copy of the abstract, consent form and data collection tools were given to the each agency.

Participants were asked to attend a discussion about HIV and AIDS. They were told the discussion would last about 90 minutes and refreshments would be served. Each participant that came to the focus group on the scheduled date was welcomed, offered a sandwich and cup of juice. As participants were eating, the researcher introduced herself and explained the purpose of the research. The consent form was also handed out and explained to the group. Questions related to the research and researcher were answered. Following this brief period, signed consent forms were collected from each young woman. The group was then asked to fill out a questionnaire. Group members were instructed not to talk to one another while filling out the survey instrument and to ask the researcher any questions they may have. Surveys were handed to the researcher as they were completed. After all surveys had been collected, the researcher reiterated that the information shared during the focus group would be used only for this research and that no identifying characteristics of any of the participants would be used in any publication related to this research. With the assistance of the group members, the researcher identified a code of conduct for the group which included confidentiality, respecting each other's opinions, and one person talking at a time. These group rules were posted in a conspicuous place. After they were established, the focus group began.

Qualitative Data Collection

Focus groups are often utilized in qualitative data collection. This method of data collection documented the experiences of young African American women, a group whose voices are often ignored by researchers and society in general. Qualitative methods of data collection seek information beyond quantitative measures and are useful when the

perspective of a group is under investigation. Collecting data on the experiences of the target population in their context provides a meaningful set of data by which the impact of gender on reproductive rights can be analyzed.[80] Qualitative data collection also allows for a more comprehensive understanding of particular issues related to the reproductive rights of young African American women. Researchers that advocate for feminist research strategies argue that qualitative methods allow for "individual women's understandings, emotions and actions in the world must be explored in those women's own terms."[81] This method also tends to represent a clearer, more holistic picture of the research topic.

Five focus groups were conducted with 37 African American adolescent females from two agencies: the Plain Talk Program of the Center for Black Women's Wellness and West End Medical Centers, Inc. during January through March, 1997 (N=37). Permission was obtained through a signed consent form.[82] This allowed the researcher to tape record the sessions. During the focus groups, information on contraceptive use, condom use and attitudes and HIV/AIDS knowledge was elicited.[83] Informal discussions were also conducted with a community health worker, three nurse midwives and an obstetrician in the data collection sites. These discussions provided information on the perspectives of health care providers and aided in the systems knowledge of the population. Table 4 provides

---

[80]Paul D. Leedy, *Practical Research Planning and Design*, 5th ed., (New York: Macmillan Publishing Company, 1993), 144.

[81]Toby Epstein Jayaratne and Abigail Stewart, "Quantitative and Qualitative Methods in the Social Sciences: Current Feminist Issues and Practical Strategies," chap. in Beyond Methodology: Feminist Scholarship as Lived Research, ed. Mary Margaret Fonow and Judith A. Cook (Bloomington, IN: Indiana University Press, 1991) , 85.

[82]See Appendix A.

[83]See Appendix C.

information on the location of the focus group, date the group was held, number of participants, ages of participants, and incentives given for each group.

TABLE 4

PROFILE OF FOCUS GROUPS

Location of Focus Group	Date/Time	Number of Participants	Age range of Participants	Incentive	Comments
WEMC, Inc.	January 16, 1997 6:00 - 7:00 pm	7	15 - 22	gift bag	informal discussion w/ midwives
WEMC, Inc.	January 24, 1997 4:00 - 6:00 pm	8	16 - 20	gift bag	informal discussion w/MD
WEMC, Inc.	February 21,1997 3:00 - 5:00 pm	6	15 - 19	gift bag	
CBWW	March 21, 1997 7:00 - 8:15 pm	8	13 - 17	$10.00	
CBWW	March 21, 1997 6:00 - 7:30 pm	8	13 - 16	$10.00	

Quantitative Data Collection

Quantitative data can be used to identify certain trends in behavior and to collect demographic data. After a brief introduction and explanation of the nature of the study, participants were given surveys to complete in the presence of the researcher in the event that the respondents required assistance with questionnaire items.[84] Most of the respondents completed the instrument without difficulty within a 20-minute time period. Data analysis

[84]See Appendix B.

using EpiInfo 6.0 allowed for the measurement of knowledge, condom use and the impact of gender on contraceptive behavior.

The survey was constructed by the researcher based on the variables that were to be assessed. It consisted of 30 questions and was divided into three sections designed to measure knowledge levels, condom use prevalence and the impact of gender on the reproductive behavior of the study population. Each section used an unweighted submitted scale. The first section measured the level of knowledge of the sample population by assessing the number of correct answers on questions 1 to 9; 1 to 3 positive responses indicated a low level of knowledge, 4 to 6 positive responses indicated a moderate level of knowledge and 5 to 7 positive responses indicated a high level of knowledge.

The second section inquired about the sexual practices of the respondents. Questions 10-13 related to condom use. Frequency of use was measured on a 5-point scale with each value being as follows: 1= Always, 2=Often, 3=Sometimes, 4=Rarely and 5=Never. Reasons for condom use were also assessed as was condom use during last sexual encounter. This measure is often used by social scientists as a determinant of frequency of use.

Questions 14-20 related to the impact of gender on the reproductive behavior of the sample population. The questions were answered on a 5 point scale with each value being as follows: 1= Always, 2=Often, 3=Sometimes, 4=Rarely and 5=Never.

Study Sample

The study sample is 37 African American adolescent females who reside in metropolitan Atlanta and are residents of underserved communities. They received health care services through clinics of Fulton County Health Department or West End Medical

Centers, Incorporated. The age range of the respondents was between 13 and 22. The two sites where the research was conducted were chosen because they were known and trusted in the community as reliable sources for health information and reproductive health services. The two organizations had a well-established rapport with adolescent females and are an important part of the communities they serve.

CHAPTER 4

AFRICAN AMERICAN WOMEN AND THEIR STRUGGLE FOR REPRODUCTIVE RIGHTS

This document emphasizes unintended pregnancy and its consequences among African American female adolescents. However, an additional analysis of specific challenges that African American women have experienced and their relationship to reproductive autonomy is important. This places the research topic within a historical context that focuses on all African American women and adolescent females in particular. Reproductive rights is a concept that includes the right to control one's own body as well as the complete physical, mental and social well-being of all matters related to one's reproductive health.[1] This ideology also implies that people have the right to decide if, when and how often to reproduce. The platform of reproductive rights has historically caused racial and gender conflicts for African American women, with examples being found throughout the history of the United States.

This chapter provides a discussion of specific efforts aimed at controlling the reproductive behavior of African American women and highlights the pertinence of this issue as it relates to this population. In this section, a brief description of the historical context

---

[1]Mueller, Ruth Dixon, Population Policy and Women's Rights: Transforming Reproductive Choice, (Westport, CT: Praeger Publishing Co., 1993) , 12-14.

through which African American women developed a need to control their fertility is offered. This includes historical data on enslaved African women and a concise discussion of the development of the birth control movement. This chapter also provides an account and analysis of a clinical drug trial aimed at reducing vertical transmission of HIV for its contemporary contribution to the debate surrounding the reproductive control of African American women in the United States.

The previous chapter described how reproductive control efforts are implemented through contraceptive technologies that are believed to offer women more reproductive control although, in fact, these methods ultimately control when and if women will reproduce. The historical accounts explored in this chapter illustrate that African American women have been denied their reproductive rights. Analysis of these episodes shows how attempts to control reproduction have been shrouded in arguments that claim a humanitarian approach to improving the quality of life for unborn children. However, these humanitarian advocates ignore the desires and health outcomes of African American women.

Specific efforts at reproductive control can be observed through case analyses of two social and health issues that took place in this country: the birth control movement initiated in the early 1900s and more recently, a clinical drug trial to reduce vertical transmission rates of HIV. Although one can argue that there are additional issues that may illustrate race, class, gender politics and reproductive rights, the point of highlighting these specific events

is to give a brief synopsis of historical factors that inform the struggle among African American women reproductive autonomy.

The development and subsequent establishment of the birth control movement which began a little over a century ago resonated with racial and class preferences. More recently, the ACTG 076 study which took place in this decade also relied upon similar racial and class sentiments. Discussion of these two examples allows one to parallel racism of the late 1800s with that of the late 1900s. In each of these situations merely being African American and female serve as obstacles to the achievement of individual reproductive self-determination. The underlying premise in each scenario is that the reproductive behavior of African American women needs to be controlled by other individuals. However, contrary to this perspective, there is a demonstrated need and desire of African American women to have control over this basic human right.

The struggle of African American women to exercise their right to reproductive freedom and maintain reproductive rights is a battle that has been fought since the forced migration of African women to the shores of America. Evidence of this struggle can be found in actions by African American women that sought to control fertility despite attempts by white men to promote it. As Loretta Ross notes, the desire by African American women to control their fertility under the inhumane conditions of slavery was a deliberate statement by African American

[2]Loretta Ross, "Reproductive Rights and African American Women" (May 1993), 1, mimeographed.

plantations of women not having children. John Morgan, a physician in rural Tennessee reported the effectiveness of camphor in controlling fertility. He writes:

> From the extent it is employed, it must effect something. It is employed extensively as a preventive of conception;...they take it just before or after menstruation, in quantities sufficient to produce a little nervousness for two or three days; when it has effect, they consider themselves safe...A good many women who are not fruitful after the first birth, use camphor freely, and I have frequently detected its use in this way by the effect of secretions.[3]

The institution of slavery mandated that African American women's bodies were the property of their enslavers. The continuity of enslavement depended upon the reproduction of slave labor, a "responsibility" of enslaved African American women. This was achieved by slave breeding which was a common practice among enslavers. Robert Weisbord, author of Genocide? Birth Control and the Black American, states "...certain slave women with proven or anticipated fecundity were deemed especially valuable as 'breeding wenches'."[4] Especially fertile women were encouraged with rewards such as freedom and special privileges during pregnancy.[5] Conversely, barren slave women commanded comparatively low prices at the auction block. A number of social historians have documented active participation by men and women to control the number of children born into the brutal conditions of slavery. Henry Bibb, a slave, wrote of his only child, "She was the first and

---

[3]Herbert G. Gutman, Slavery and the Numbers Game: A Critique of Time on the Cross, (Chicago: University of Illinois Press, 1975) , 78.

[4]Robert Weisbord, Genocide? Birth Control and the Black American (Westport, CT: Greenwood Press, 1975), 26.

[5]Ibid.

last slave that I will ever father for chains and slavery on this earth."[6] During slavery in this country, a demonstrated, documented need for African American women to prevent conception was borne.

As the end of legal slavery came, African American women believed that they would now be given opportunities for advancement in all aspects of their lives, including reproduction. However, the social constructs of race, class and gender prevented this from being actualized. Following the era of enslavement, other discriminatory practices were implemented to control the reproductive behavior of African American women such as the exclusion of African American women from the birth control movement and forced sterilization. Though legally, African American women had been granted freedom and full rights, Eurosupremacist tactics continued to deny reproductive rights and freedom to African American women.

The Politics of the Birth Control Movement

Reconstruction symbolized achievement not only for black women but also for white women. Black women were able to escalate their involvement in informal and formal vehicles devoted to ending racial inequality, were legally allowed to attend school and receive wages for work. For white women, this period represented the opportunity to continue activism around social issues, including reproductive freedom. Even though white and African American women recognized the need for reproductive freedom, the methods to achieve this and the motives for it were very different for each group. White women were

---

[6]Ibid., 28.

primarily concerned with establishing the right to control their fertility through abstinence and/or voluntary motherhood in order to maintain the notion of true womanhood. Their primary desire was to obtain the ability to work outside of the home. Ironically, African American women worked outside of the home - often in the homes of white women, caring for their children. This era brought about the active desire of African American women to exercise their fundamental right to control giving birth to children in a racially divided society. Giddings[7] notes that by the 1900s black women were marrying later and having fewer children than in years prior to Reconstruction.[8]

During the mid to late nineteenth century, white women organized around issues related to suffrage, motherhood, birth control and sexuality. Demand for suffrage was a demand for a major change in the status of women as traditionally dependent in that it challenged the idea that women's interests were identical to or compatible with interests of men.[9] Birth control reinforced this issue. Buechler notes that by the end of the nineteenth century the women's movement was clearly divided among racial and class issues.[10] The racial and class differentiation of women made it increasingly difficult to find unity on any

---

[7]Paula Giddings, When and Where I Enter: The Impact of Black Women on Race and Sex in America (New York: Bantam Books, 1984) , 137.

[8]Throughout Africa, the population growth rate is a concern. Interestingly, the lowest fertility rates are often documented among educated women who have been found to marry later. These women have been reported as having fewer children.

[9]Steven M. Buechler, Women's Movement in the United States: Woman Suffrage, Equal Rights and Beyond (New Brunswick, NJ: Rutgers University Press, 1990) , 93.

[10]For more information, see Buechler's Women's Movement in the United States: Woman Suffrage, Equal Rights and Beyond (New Brunswick, NJ: Rutgers University Press, 1990).

one issue.[11] These divisions were dictated by the social climate of the period and further contributed to the exclusion of African American women in the struggle for women's equality, particularly in the development of the birth control movement.

The birth control movement was developed in the late nineteenth century as an agent for social change and initially emerged among white women as a campaign for voluntary motherhood which advocated for long periods of sexual abstinence for married couples as a remedy for unwanted children.[12] When one examines the gender disparities in the relevance of the birth control movement, marked differences between white men and women in relation to the need for fertility control are demonstrated.

Until the age of industrialization, the patriarchal view of motherhood maintained that the only appropriate reason for sexual intercourse was reproduction.[13] Furthermore, motherhood was regarded as the primary vocation for white women and also a measure of social worth. Thus, the birth control movement was initially met with rejection by white men. White women desired to control their reproduction using a Victorian method - sexual abstinence. Supporters of voluntary motherhood advocated against contraceptive devices as they were viewed as unnatural and it was believed that they would create promiscuity among women, thereby destroying the virtuous woman.[14] Ironically, white women did not

---

[10]Carole McCann, Birth Control Politics in the United States, 1916-1945 (Ithaca, NY: Cornell University Press, 1994) , 2.

[12]Ibid., xii.

[13]Linda Gordon, Woman's Body, Woman's Right: A Social History of Birth Control in America (New York: Grossman Publishers, 1976) , 22.

[14]Ibid., 98.

acknowledge the possibility that contraceptive devices may have also increased the likelihood of male infidelity.

During enslavement, the notion of true womanhood went largely unchallenged because African and African American women were the primary suppliers for the unpaid labor force and were not viewed as human beings, much less true women. Thus, support for the Victorian notion of an African American woman was not relevant in Eurosupremacist society. In fact, for African American women, motherhood was not the primary vocation, maintaining the wealth of the slave owner was. Furthermore, images about the sexuality of African American women were developed.[15] Given the widespread acceptance of these images, even today, they have continually served as mechanisms of oppression for African American women in all aspects of their lives.

The view of African American women developed during slavery and maintained through this century was a hostile one, often portraying African American women as jezebels and sexually insatiable.[16] This view, held by both white women and men, has served as justification for reproductive control through modern times. During the birth control movement, controlling images of African American women were supported and reinforced the notion that African American women were not "worthy" of the right to control their reproductive behavior. Consequently, there was no perceived need on the part of white

---

[15]Patricia Hill Collins, "Mammies Matriarchs and Other Controlling Images," chap. in Black Feminist Thought: Knowledge,Consciousness and the Politics of Empowerment (New York: Routledge Press, 1991) , 71.

[16]Melvina Johnson Young, "Exploring the WPA Narratives: Finding the Voices of Black Women and Men," in Theorizing Black Feminisms: The Visionary Pragmatism of Black Women, eds. Stanlie James and Abena Busia (London: Routledge Press, 1993) , 65-68.

women for an alliance between themselves and African American women in the struggle for reproductive freedom.

There was virtually little support by white feminists for African American women who wanted to control their fertility. Being black and female were not valuable qualities to the development of post-Civil War America as evidenced by the perception of the sexuality of African American women, the exclusion of African American women from the right to vote in the early 1900s and the racist ideologies that sought to control the fertility of African American women. As a result of the underlying practice of Eurosupremacy, racism and sexism were the prevailing notions and were reflected throughout society, including the birth control movement. Consequently, African American women were excluded from this movement even though there was a clear need and desire by them to control their fertility. In addition to the impact that race and gender had on the birth control movement, class also played a large role, particularly as it relates to the legalization of contraception.

One of the most noted scholars in the area of the history of the birth control movement is Linda Gordon, author of Woman's Body, Woman's Right: A Social History of Birth Control in America.[17] Gordon's work provides an excellent analysis of the race, class and gender politics that shaped the formation of the birth control movement. This author argues that this movement passed through three stages. Stage one focused on freedom

---

[17]Linda Gordon, Woman's Body, Woman's Right: A Social History of Birth Control in America (New York: Grossman Publishers, 1976).

and autonomy for women. Voluntary motherhood was the vehicle through which freedom was sought. During the second stage, the term "birth control" was coined.

The advocates of birth control were largely from professional families who subscribed to the belief that the white race in America was under the threat of extinction. As this was believed by some to be the case, immigrants and African Americans were viewed as having large numbers of children which would increase the non-white population. Thus, birth control was seen as necessary to control the number of non-white children born.

The issue of class is inherent in Stages one and two but is explicitly exhibited in Stage three. This period is characterized by a liberal reform movement initiated by socialist, Margaret Sanger. It was during this stage that the term "planned parenthood" came into use and family planning services specifically aimed at lower-income women were developed and implemented.[18]

Angela Davis also provides an analysis of the racial, gender and class politics of the birth control movement in Women, Race and Class.[19] Unlike Gordon, this analysis is done from an African American perspective. The analysis Davis offers clearly illustrates the role that race played in the development of the birth control movement. Davis argues that the legacy of slavery served as a foundation for the exclusion of African American women from the birth control campaign. Furthermore, strategies that exhibited blatant racism were

---

[18]Gordon, 77-89.

[19]Angela Y. Davis, "Racism, Birth Control and Reproductive Rights" chap. in Women, Race and Class (New York: Random House, 1983) , 202-221.

employed, such as those advocated by Margaret Sanger. Sanger's racism was most apparent in her support of Eugenicism.[20]

Sanger is often championed as an autonomous founder of the birth control movement. However, Sanger's role was that of an anchor for the movement. She situated birth control within the social and economic institutions she was a member of as well as fought against. Reed notes, "By providing social justification for practices that had wholly seemed personal and selfish," Sanger forced the public to acknowledge an option for women.[21]

Unlike the early founders of the birth control movement, Sanger appeared expressly concerned with the plight of lower-income women who were often women of color, and demonstrated a commitment to improve the health conditions of women who did not have access to contraception. She maintained that access to contraception was women's fundamental right. To achieve this goal, Sanger set up family planning clinics in low-income neighborhoods in New York City and her activism was instrumental in the 1916 legalization of contraceptive technologies. She adamantly argued that women who had regained control over their bodies "would become a revolutionary force by choosing to rear children only under the best possible conditions, thereby eliminating not only poverty but mediocrity as well."[22] However, in later years, Sanger's activism complemented the ideology of the Eugenicists in that it advocated for birth control as a means to address the issue of the declining fertility rate of the dominant society in comparison to the African American and

---

[20]Ibid., 210-215.

[21]James Reed, From Private Vice to Public Virtue: The Birth Control Movement and American Society Since 1830 (New York: Basic Books Inc., Publishers, 1990), 68.

[23]Ibid., 65-72.

immigrant populations. To achieve this goal, Sanger supported the use of methods such as permanent sterilization and forced celibacy through institutionalization in mental health facilities for those they considered to be the unfit. Later tactics included advocacy for the use of specific contraceptives for specific populations. Sanger used the Eugenicist argument of racial betterment and improved racial health as a tool to gain medical support and public support from the middle and upper classes for contraception.[23]

The ideology of Eugenicism advocates for the preservation of the European race through the prevention of the birth of non-white babies. This was the vehicle that defined the purpose of birth control, thus ultimately defining parameters for reproductive freedom. Under this definition, birth control became a method of population control as opposed to a means of developing and nurturing reproductive autonomy.[24] So, early during the development of a movement designed to offer women emancipation, the method by which autonomy would have been achieved became associated with controlling reproduction. In conjunction with this new definition of birth control, there was an extreme fear among whites that their declining fertility rate posed a threat to maintaining the existent power structure. Actually, however, the actual fertility rate of African Americans steadily decreased during the first three decades of this century.

Thomas Littlewood, author of The Politics of Population Control, attributes this decline to a poor health hypothesis. This theory argues that fertility rates declined as a result of poor health status among blacks, particularly males who were infected with syphilis or

---

[23]Ibid., 108.

[24] Dorothy Roberts, Killing the Black Body: Race, Reproduction and the Meaning of Freedom (New York: Pantheon Press, 1997) , 80.

gonorrhea. He argues that in most Northern cities, the death rate increased during the early 1900s while the birth rate was falling, resulting in a zero rate of increase.[25] However, Dorothy Roberts, author of Killing the Black Body: Race, Reproduction and the Meaning of Freedom, challenges this popular notion, stating that the "health hypothesis" failed to consider that African American women's use of birth control methods during this period. She posits that middle class blacks had low levels of disease related to infertility and low fertility rates.[26] This suggests that contraceptives were being utilized effectively among African American women and perhaps, their partners.[27]

Although the concern of white America during the early 1900s was unjustified, the dominant society felt threatened and acted upon their fears. Influential political figures such as President Roosevelt argued that White women and men who used birth control were essentially practicing race suicide. On the other hand, leaders in the Black community, such as Marcus Garvey, noted the importance of maintaining high birth rates and warned that Blacks "might be exterminated if they allowed themselves to be weakened by a reduction in population size."[28] In all arenas, African American women were discriminated against. They were ostracized from the movement for reproductive freedom by white women; they experienced racial and sexist oppression from white men; Black men sought reproductive control. Ultimately, their needs and personal desire to control their own fertility were

---

[25]Reed, 108

[26]Roberts, 90.

[27]Ibid., 83

[28]Reed., 70.

silenced by the needs of the dominant society, thereby increasing the challenge for African American women's voices to be heard on this issue.

The development of the race and gender oppression that African American women endured during the development of the birth control movement is an extension of the oppression they faced since coming to these shores. The foundation of this targeted oppression can be found in images of African American women that were developed during enslavement. As noted earlier, the capitalist economy saw a need to control the fertility of African American women in order to maintain wealth. In addition to specific efforts that sought to control fertility, the use of opposing images of African American and white women (e.g. true womanhood versus jezebel) served as barriers for African American women. While the wives of the enslavers were encouraged to aspire to the notion of true womanhood, the perception of the African American woman as sexually insatiable and as a breeder woman prevented their inclusion in the cult of true womanhood.

An analysis of this historical narrative provides a context in which to view the struggle for reproductive freedom. The development of the birth control movement is significant because it demonstrates that almost from its inception there was a perception that the reproductive needs of poor African American women were insignificant, a view that is continuously perpetuated in present-day debates around reproductive rights and freedom for African American women of all ages. Essentially, the issue of who controls contraception and ultimately, reproduction has not changed over time. An excellent contemporary example of how race, class and gender impacted on the reproductive rights of African American

women and HIV/AIDS can be observed in the ACTG 076 Study, a clinical drug trial that targeted pregnant women who were infected with HIV.

The ACTG 076 Study

One of the most glaring issues related to the impact of race, class, gender and age variables on HIV is demonstrated in the study that sought to reduce vertical transmission of HIV[29] through the use of zidovudine (AZT). Perinatal transmission accounts for the majority of HIV infection among children globally. In the United States, between 1,000 and 2,000 children are born to HIV infected mothers annually.[30] Although women who are HIV positive and give birth are educated on ways to prevent transmission of the virus to their children after birth, infection can still occur in utero or during birth.

In an effort to prevent this, a number of organizations and governmental agencies, including the AIDS Clinical Trial Groups (ACTG), the National Institute of Allergies and Infectious Diseases (NIAID) and the National Institute of Child Health and Human Development (NICHHD) collaborated on a study (ACTG 076) to investigate whether giving AZT to pregnant women who were infected with HIV would prevent vertical transmission of HIV.

The prophylaxis was given during pregnancy and labor as well as to newborns for six weeks after birth. The study was initiated in April 1991. Participants in the study were

---

[29]See "Definitions" section for explanation.

[30]Michael Howe, "Zidovudine for the Prevention of HIV Transmission from Mother to Infant,"AIDS Information Newsletter: Women and HIV Infection: Part XIII , 18 November 1994.

women who were between the ages of 15 and 43, were living with HIV and began the study between the 14th and 34th week of gestation. About 50 percent of the women were African American, 33 percent Hispanic and 17 percent were white. In order to participate in the study, AZT could not have been used by any of the women prior to enrollment and the participant's T-cell counts[31] had to have been greater than 200 at the start of the study.

About eighteen months after the study began, NIAID issued a press release stating that enrollment in the study had ceased because the results proved that taking AZT during pregnancy was effective in reducing the rate of vertical transmission of HIV. The principal investigators of the study also issued treatment guidelines for pregnant women infected with HIV that were designed to be used by physicians. These guidelines recommended that standard treatment for HIV positive pregnant women should be AZT. Although preventing the risk of vertical transmission would be a great benefit to the health of women and their children, there were a number of medical and ethical issues that arose from this study.

Firstly, in order to be eligible, women had to have T-cell counts of at least 200. However, the trial did not test the efficacy of the regimen on women who had T-cell counts lower than 200 or among women who had previously used AZT for extended periods. In fact, more than 50 percent of the women had T-cell counts over 500 at the start of the study and some women had counts as high as 1800.[32] This is significant because women with

---

[31]A normal T-cell count is about 1,000. See "Definitions" section for further an explanation of T-cells.

[32]National Library of Medicine-HIV/AIDS Treatment Information Service, "About the Women in the AZT Study" (Rockville, MD: National Library of Medicine, 1997).

counts of 1800 are classified as in the early stages of infection with HIV and would not have been prescribed the medication at this point under routine medical care for HIV infection.

Research has also found that people who take AZT may develop resistance to the drug. So, if women in the clinical trial needed to take AZT in the future, they may have unknowingly developed a resistance to it because of their prior use of AZT during pregnancy. Women Alive, an organization that advocates for women's rights, alleges that none of this information was presented to the women before they consented to participate in the 076 study. Therefore, the women did not give informed consent.[33]

Secondly, NIAID and its collaborating organizations in the study claimed that using AZT would significantly reduce the number of children born infected with HIV. This is, in fact, not substantiated. It is important to note that only 20-30 percent of children born to HIV positive women will be infected with HIV. In addition, for the 70 or 80 percent of children whose mothers are HIV-infected but are not infected themselves, AZT may place the children at risk for other medical complications. The effects of AZT on the fetus during the first trimester are unknown as are the effects of AZT on the mother. Therefore, the claim that the study will save children's lives may be unsubstantiated.

Furthermore, participants were randomly selected to receive either AZT or a placebo in the "double blind study."[34] However, the side effects associated with AZT can be seen in blood samples which were drawn as part of the research. Therefore, physicians could have

---

[33]Body Health Resources Corporation-The Body, "Mother-to-Infant HIV Transmission 076 Update: Can We Believe Them?" (New York: Body Health Resources Corporation, 1997).

[34]In a double blind study, neither the researchers nor the women know who receives the placebo and who receives the drug.

known who received AZT and who received the placebo.[35] Thus, it was not double-blind. In addition, although the study claimed 364 women and children participated, when the study was halted eighteen months after its inception, only 75 children had been involved. It was also unclear how many of these participants received AZT or the placebo.

Finally, the issue of greatest concern is the age and ethnicity of the participants. Most of the participants were African American and Latina women and a large majority were less than 20 years of age. Older women refused to participate because they apparently were concerned about the effects of the drugs on the fetus. The ethical and medical concerns of this study clearly echo issues related to reproductive rights for women, particularly for African American and Hispanic women as they comprised over 80 percent of the study participants and are at greater risk for HIV infection than their white counterparts.

The women in the study were informed of the perceived benefits - that their unborn children would not be infected with HIV. However, they were not informed of the potential risks of long-term AZT therapy. Another factor to be taken into consideration is that many women may have limited access to health care. In this scenario, it is conceivable that the findings that occurred in the controlled environment of the 076 study could not be achieved in reality. Despite these concerns, the NIAID did establish interim guidelines for treatment of HIV positive pregnant women which support counseling infected women on the use of AZT. The potential for coercion is great. Health care providers, whose aim is to maintain the health of their clients, may believe that AZT is the best treatment for HIV infected

---

[35]Women Alive, 1.

pregnant women, regardless of the woman's medical history or her feelings about taking the drug.

As the rate of HIV infection and unintended teenage pregnancies increases among adolescent females, it is understandable why vertical transmission is a matter of concern. However, in order to prevent HIV transmission, it is essential to examine the social factors that may contribute to HIV infection among women, especially adolescents in order to develop protocols, policies and programs to prevent the spread of disease. Moreover, inadequate treatment is unethical and should not be the standard for a specific group of people, who, in this case include African American women, who are often rendered powerless.

This controversial clinical drug trial illustrates a compromise of the reproductive rights of young African American women. Given that the study population in the current study is between 13 and 22 and because of their life circumstances, there is a possibility that these young women will experience an unintended pregnancy and as a result of unprotected sexual intercourse, possibly become infected with HIV. For this reason, it is necessary to examine cases such as the ACTG 076 study to understand how efforts at reproductive control are played out in the lives of African American adolescents. Since participants did not receive true informed consent, this study threatened constitutional and statutory rights, including the right to privacy. It also threatened the right to make informed decisions about individual health care and the care of an unborn child. Finally, this case analysis allows one

to draw a parallel between the denial of reproductive rights for the target population and the possibility of a denial of these same rights for a similar cohort in a similar situation.

Ironically, the image of the African American woman in the ACTG 076 study is quite different than the image portrayed during enslavement. During slavery, the image of the African American woman as breeder woman was deemed appropriate. This image allowed for the idea that they were more suitable to bear children than their white counterparts and established a powerful racist stereotype. It also established the use of controlling images as vehicles for oppression. The image of the lower-income woman in the ACTG 076 study is one of the "welfare mother." This contemporary personification provides justification for reproductive control.

Collins notes that the controlling image of the welfare mother portrays African American women as lazy and as the cause of her poverty. The developers of this image did not take into consideration the underlying causes of poverty. The African American woman as the welfare mother developed in response to the large numbers of undereducated and unemployed African American women who reject the abusive jobs of their parents and ancestors. Collins posits that the advent of post-World War II public assistance programs helps to perpetuate the notion that the state has the right to control the reproduction of African American women because it supports them.[36] Furthermore, the image of the welfare mother as unproductive, unmarried and having bad values which are passed on to the

---

[36]Collins, 76.

multitude of children she bears that are supported by the state provides additional reasons for the need to control the fertility of African American women.

In addition to this image, public assistance programs offer African Americans the option of not being exploited as cheap labor and thus, "Signify a costly threat to political and economic stability."[37] Consequently, the power structure becomes threatened and finds additional reasons to promote reproductive control. As Angela Davis notes, the thesis of the welfare mother "provides ideological justification for the dominant group's interest in limiting the fertility of Black mothers who are seen as producing too many economically unproductive children."[38]

The view of the African American woman as jezebel and the welfare mother are controlling images. These two interpretations of the reproductive behavior of African American women contribute to the formation of an ideology that interprets Black female sexuality and fertility. This ideology of domination also clearly identifies the role of African American women in the political economy. These images also present themselves in the daily life of African American women. Thus, the images become internalized and the targets of the images become self-fulfilling prophecies.

The African American adolescents in the current study are the granddaughters and great-granddaughters of the women who were involved in the development of the birth control movement; they are the peers of the participants in the ACTG 076 study. These young women are the inheritors of the struggle for reproductive freedom. They are also

---

[37]Ibid.

[38]Davis, 75.

active participants in this struggle because they have been targeted as ideal clients of contraceptive technologies that result in the erosion of their reproductive rights at the expense of their health.

The examples provided illustrate the reality that during various points in the history of African American women's health, they have been ignored, actively rejected and blatantly discriminated against, even if the health issue was life-threatening, as in the case of HIV. Furthermore, views of African American women, their sexuality and their reproductive behavior that were established during enslavement have been perpetuated throughout history. As Collins notes, the stereotypical images of African American women must be continually manipulated in order to maintain the white power structure.[39]

The paradox in ideologies held by the patriarchal ruling class is interesting. A little over 100 years ago, reproductive control took a different form in that its aim was to increase the wealth of European enslavers. Today, it manifests as controlling unintended pregnancy among non-Europeans through specific contraceptive technologies that may compromise the health of African American women, including adolescents and as in the ACTG 076 study, HIV positive pregnant women. Race, class and gender issues around issues related to reproductive rights have pervaded the history of the United States.

---

[39]Collins, 68.

CHAPTER 5

AFRICAN AMERICAN ADOLESCENT FEMALES IN ATLANTA AND REPRODUCTIVE RIGHTS

This chapter is dedicated to presenting an overview of: 1) the influence of health care providers on reproductive health choices, 2) the level of knowledge regarding HIV prevention that African American adolescents have, 3) the ways in which they practice safer sex and 4) the role that gender plays in sexual relationships between African American adolescent females and males. To this end, information on sites where data collection took place, characteristics of the population, HIV prevention knowledge, safer sex practices and the influence of gender on condom use are also included in this chapter. The objective of the primary data collection was to determine the extent to which African American adolescent females in Atlanta, Georgia exercise their right to reproductive freedom.

In order to examine this, it is necessary to briefly discuss the influence of health care providers on the reproductive health choices of the target population. A significant portion of the literature on contraceptive use emphasizes the impact of the health care providers on clients' choice of contraceptives. The providers interviewed noted that unintended pregnancy is one of the major problems facing teenagers and their community. All providers identified that unintended pregnancy, particularly among teenagers, as a major problem in their community. Providers believed that one of the reasons for the high rate of teenage

pregnancy is the age of the girls. Oftentimes, the girls lack experience with contraceptives and do not exhibit a level of maturity that is necessary for taking oral contraceptive pills as needed. Therefore, methods that require little user responsibility are preferred to prevent pregnancy. It is important to note, however, that all providers stressed that they encouraged their clients to use condoms in addition to their primary method of contraception. Even though condom use is encouraged, research on dual contraceptive use has found that if a client perceives their primary method of contraception as effective at preventing pregnancy (e.g., oral contraceptive pills or Depo Provera), rates of condom use in addition to the primary method are very low.[1]

Discussions with participants revealed that the reproductive health knowledge these adolescents acquired had been transferred from their health care providers. Participants made reference to previous conversations with providers. The words of one provider best summarized the overall philosophy of the participants towards contraception, stating that the best way to prevent pregnancy was to use methods that "no one could know about, like Depo." In this situation, advocacy for Norplant and Depo Provera is seen as benefitting the health care status of the young women and ultimately the community at large because it will prevent an unintended pregnancy.

Data Collection Sites

The respondents from the study were recruited from the Plain Talk Program, a program of Center for Black Women's Wellness (CBWW) and West End Medical Centers,

---

[1]Margaret Frank et. al. "Characteristics and Attitudes of Early Contraceptive Implant Acceptors in Texas," Family Planning Perspectives 24 (1992) : 229.

Inc. (WEMC). Both of these organizations are dedicated to providing reproductive health care services in underserved areas. The Plain Talk Program is housed in the Dunbar Community Center, a city-owned and operated center, located in the Mechanicsville neighborhood of Atlanta. Mechanicsville encompasses the McDaniel-Glen Housing Development. Data from the 1990 census reports that there are 1,296 households in this area -- including subsidized housing, private residences and public housing developments. The majority of the 3,323 people living in Mechanicsville are African American (97 percent) and almost half of these (44%) are under 20 years of age, with 44 percent of these being between the ages of 10 and 19.[2] In addition, 62 percent of Mechanicsville residents 25 years and older do not have a high school diploma.[3] Coupled with the low level of formal education, the employment rate for those aged 16 years and older is 31 percent.[4] Poverty levels in this community are high; 71 percent of the population lives below the poverty level and the median household income is about $4,500 per year.[5] This neighborhood also has high rates of unintended pregnancy among adolescents.

The second site where data were collected was WEMC . This health care organization was established over two decades ago to provide comprehensive, accessible health care services at affordable prices to residents and at-risk populations in the West End and greater Atlanta areas. This mission is accomplished by providing information designed

---

[2]Annie E. Casey Foundation, "Plain Talk Program: A Summary of the First Year," (Baltimore: Annie E. Casey Foundation, 1997) , 1.

[3]Ibid.

[4]Ibid.

[5]Ibid.

to cultivate health seeking behaviors, lifestyles and wellness. WEMC also provides comprehensive health care services and has nine sites in the greater Atlanta area. These sites offer the following services: pediatrics, internal medicine/family practice, OB/Gyn, inpatient services, dental care, nutritional services, social services and support services. The satellite centers are located in: East Lake Meadows, Bowen Homes, Herndon Homes, University/John Hope Homes, Juniper and 10th and the West Lake area. There is also a health care center in Little Five Points and one on Candler Road, in Decatur. The areas served by WEMC are low-income and have poor health indicators such as high rates of diabetes, cancer, pregnancy and STDs, including AIDS. Annually, WEMC delivers an average of 500 babies, serves over 26,000 patients and operates a teen clinic at a metro area high school.

Characteristics of the Study Sample

The participants in this study (n=37) were female and African American. Their ages ranged from 13 - 22 with a mean age of 15.4 years. Most of the respondents lived in Fulton County (92%) and the remainder lived in DeKalb County (8%). The educational level of the respondents varied from middle school to college. Most of the respondents indicated that they were in middle school or high school (each 43%). Over half of the participants (51%) did not have children. Of the 49% who reported having children, 80 percent had one child and 20 percent indicated that they had two children. No participant reported having more than two children. The most common form of contraceptive used by this group was Depo Provera (35%), followed by condoms (19%). Participants noted length of time of current contraceptive use which ranged from less than six months to two years. The most common response to this item on the tool was use for less than six months by a few older participants.

During the administration of the survey, adolescents were asked questions regarding methods of HIV prevention and transmission of HIV. After reviewing the responses to these questions, it was determined that 22 of the participants demonstrated a high knowledge level and 12 demonstrated a moderate level of knowledge. According to the knowledge scale previously defined in the research design, most of the young women stated that they did use condoms (84%), with 51.4 percent indicating that they "always" used condoms. Further, 70.3 percent indicated that they used condoms to prevent STDs and pregnancy, and 68 percent indicated that they had used a condom the last time they had sexual intercourse. Adolescents who used condoms during their last sexual encounter were considered consistent condom users. Table 4 provides detailed demographic and condom use data for the study population.

Knowledge

In general, most of the young women had a high level of knowledge. The mean number of positive responses was 7 out of 9, with a range of total positive responses from four to nine. When asked if condom use can protect one from AIDS, 83.8 percent responded positively. Seventy percent of respondents were aware that using a condom can prevent transmission of HIV. Almost 90 percent of the participants knew that there was not a cure for AIDS and almost all of the participants (95%) knew that it was not a "homosexual disease." Thirty three of the females answered the question regarding vertical transmission

correctly, however two answered incorrectly and two did not know if a mother could infect her unborn child with HIV while pregnant.

The largest discrepancy with regards to knowledge was found when respondents were asked if a person who was infected with AIDS but looked and felt healthy was capable of infecting others. Only 70 percent of the respondents answered correctly and eleven respondents either indicated that they did not know or answered incorrectly. Although the respondents in the current study demonstrated a significant level of knowledge on HIV transmission and prevention, there was a low level of knowledge regarding contraception as a method of HIV prevention, with only 24 respondents answering the question regarding use of contraceptives as an HIV prevention method correctly and 13 indicating that they did not know if using birth control pills would reduce transmission of HIV. Table 5 shows the number of respondents who answered in each category of the section on HIV/AIDS knowledge level.

Safer Sex Practices

Due to the fact that heterosexual transmission accounts for the majority of incident cases of HIV infection, obtaining information about sexual practices was necessary. The questions in this section referred to sexual practices within the last six months of the survey. In addition, questions were structured to elicit information on condom use, frequency of use, reasons for condom use and whether or not the respondent had used a condom the last time

TABLE 5

CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS

Characteristic	n=37	(%)
Age	mean (15.43)	range (13-22)
13-15	20	54
16-18	14	38
19-22	3	8
County of Residence		
Fulton	34	92
DeKalb	3	8
Educational Level		
Middle school	16	43
High school	16	43
College	4	11
Other	1	3
Have children		
Yes	15	41
No	18	59
Number of children for those reporting children		
1	12	80
2	3	20
Contraceptive Method [6]		
Oral contraceptives	2	6
Norplant	2	6
Depo Provera	11	35
Condoms	6	19
Abstinence	2	6
Don't use contraceptives	7	22
Other	2	6
Length of Use		
Less than six months	13	42
One year	10	32
Two years	8	26
Condom Use		
Yes	31	84
No	6	16
Used condom at last sexual encounter		
Yes	25	68
No	12	32

[6]Five participants did not respond to this question. The data shows that they did not have any children or were not contraceptive users.

they engaged in sexual activity. The results for this sensitive subject matter section should be considered cautiously since the data were obtained through self-report.

Adolescents in this study were asked whether or not they used condoms. Eighty four percent reported condom use. Slightly over half of the respondents (51%) indicating that they "always" used a condom, 19 percent reported that they "often" used condoms and 11 percent indicated that they "sometimes" used condoms. Of all the respondents, about 19 percent indicated that they had "never" used condoms.

Respondents were also asked why they used condoms. The results of their answers are illustrated in Table 6. About 70 percent indicated that they used condoms to prevent pregnancy and STDs, while 16 percent used them exclusively to prevent pregnancy. Almost 1 percent stated that they did not use condoms at all.

Gender

Questions in the section that related to the impact of gender on condom use were raised to examine the extent, if any, to which condom use is influenced by male sexual partners. Almost three-quarters of the respondents (73%) indicated that they would always feel comfortable giving a guy a condom and 89.2 percent (33 adolescents) responded that they would "always"or "often" talk with a guy with whom they were going to have sex about condom use. This data supports previous findings that adolescent females intend to use condoms to protect themselves against pregnancy and STDs.

TABLE 6

HIV/AIDS KNOWLEDGE LEVEL

	Question	Yes	No	Don't Know
1.	Using a condom will protect you from getting AIDS	31	6	0
2.	You can reduce your chances of becoming infected by using a condom every time you have sex.	26	7	4
3.	AIDS can be cured	5	28	4
4.	Only homosexuals get AIDS	2	33	2
5.	You can get AIDS by holding hands	7	30	0
6.	Mothers can pass AIDS to their babies while they are pregnant.	33	2	2
7.	You can tell if a person has AIDS by looking at them.	2	31	4
8.	If someone has AIDS, they may never have symptoms and may feel healthy but can infect others.	26	3	8
9.	You can reduce the chance of becoming infected with AIDS by using birth control pills.	1	24	12

Of the 37 respondents, the majority stated that they could ask their boyfriend to use a condom (78%). Most respondents also indicated that they would feel comfortable giving a guy a condom if he did not have one (73%). Twenty five of the respondents (68%) indicated that they "always" would not have sex with their partner if he does not want to use a condom while only 16 percent indicated that they would "never" have sex. Although there was a considerable percentage that indicated that they felt they would opt not to engage in

sex if a condom was not used, most respondents (73%) agreed that having sex without a condom shows more love. These discrepancies serve as justification that male perceptions of condoms influence their use.

With regards to communication between male and female partners, 75 percent of the participants responded that they could "always" talk to a guy with whom they were going to have sex about using a condom and 68 percent stated that using a condom "rarely" meant that they were fooling around on him. Upon examining the data regarding the influence of gender on sexual practices, 29 of the respondents stated that they could ask their boyfriend to use a condom. These results are presented in Table 7.

In conclusion, most respondents in the current study were between the ages of 13 and 22 and were enrolled in at least middle school and resided in Fulton County. All respondents had at least a moderate level of HIV prevention and transmission knowledge. Participants also self-reported that they had used condoms previously and during at the time of sexual intercourse and stated that their reason for doing so included pregnancy and STD prevention. With regards to the impact of gender on condom use, most respondents indicated that they believed that they could ask their partner to use a condom, felt comfortable giving their partner a condom and would not have sex with a male if he would not use a condom. Furthermore, a small percentage believed that sex was not as pleasurable when using a condom. Finally, most females indicated that they could talk to their partner about condom use and that using one did not demonstrate unfaithfulness.

TABLE 7

REASONS FOR CONDOM USE

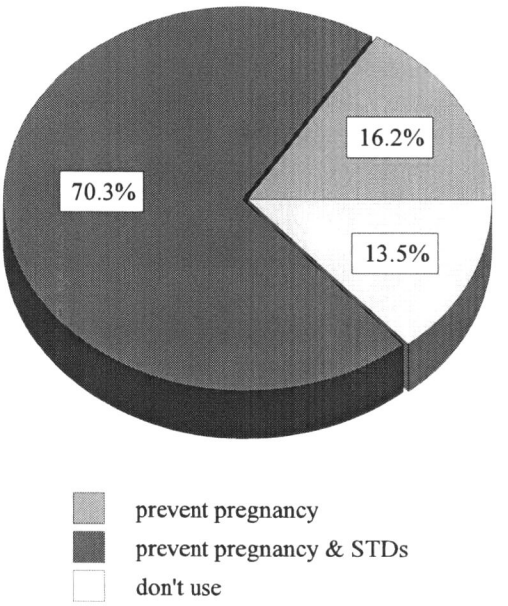


TABLE 8

GENDER- BASED QUESTIONS ON CONDOM USE

Question		Always	Often	Sometimes	Rarely	Never
14.	I can ask my boyfriend to use a condom	29	4	1	1	2
15.	If a guy does not want to use a condom, I feel comfortable giving him one.	27	2	3	0	5
16.	If a guy does not want to use a condom, I will not have sex with him.	25	3	2	0	7
17.	Having sex without a condom shows more love.	27	2	2	1	5
18.	Sex does not feel as good with a condom	5	1	2	11	18
19.	I can talk to a guy I am going to have sex with about using a condom.	28	5	1	2	1
20.	Using a condom with my boyfriend means that I am fooling around on him.	4	4	25	1	4

CHAPTER 6

REPRODUCTIVE RIGHTS IN THEIR OWN VOICES

This section describes the findings of five focus group discussions held with African American adolescent females who participated in programs and/or received services from West End Medical Centers, Inc. or the Plain Talk Program of the Center for Black Women's Wellness. All respondents were engaged in each focus group discussion. The length of discussion groups averaged about 90 minutes. Informed consent was obtained from each participant and each session was audio taped. Focus group recordings were transcribed and statements were analyzed by the researcher.

Knowledge

> Condoms protect you against STDs and AIDS. Best to use a condom, the shot, everything because you won't know for a long time if you catch AIDS.[1]

When queried about general knowledge of HIV and AIDS most of the respondents confused the two acronyms. "If you have HIV, you have AIDS," replied one respondent. Others were unsure of what the acronyms of HIV and AIDS stood for, often incorrectly stating that the "I" in both acronyms stood for "immunity" or did not know at all.

---

[1]Focus group discussion, West End Medical Centers, Atlanta, Georgia, December 24, 1997

Apparently, the acronyms are not well understood which would explain why participants had a difficult time articulating the difference between the two stages of this condition. However, participants understood that HIV/AIDS was sexually transmitted. According to one respondent, "I can't remember for sure, but you get it by having unprotected sex." Others agreed with this statement. This suggests that there is some level of prevention knowledge. However, whether or not an adolescent female considers herself at risk may depend on her interpretation of the acronym. One participant declared, "You can probably live longer with HIV than AIDS." One young woman did know the meaning of each acronym. This respondent also emphatically stated, "[The media] don't even know what the difference is because they always say HIV/AIDS or the HIV virus, that's wrong!" This statement suggests that the media is a source of health information. This is important because adolescent culture is often influenced by the media. If incorrect or incomplete information is being disseminated, there could be a misguided perception or lack of knowledge about issues related to HIV such as transmission.

Respondents were aware that HIV can be transmitted through injection drug use. Statements such as, "You can get it through a needle, through shooting up." indicated this. Perhaps this statement reflects the life circumstances of this participant. Others made statements that illustrated they had knowledge regarding condom use as a preventive factor. Respondents made comments such as, "You can get it through unprotected sex" and "having sex without a condom." The facilitator asked if one could tell if someone had AIDS and was told by one respondent, "Not all people get AIDS, only the bad ones." When the focus group facilitator probed as to what the young woman meant by "bad people," she responded, "You know, the kind that do it with everybody." This suggests that the perception of sexual

promiscuity is not a cultural norm among adolescents. This statement was followed by an acknowledgment that female peers who have sex with more than one partner, "..Don't think they need to use a condom. That's what girls these days think." Again, sexual promiscuity is not valued by this group. In the case of promiscuity, it is of note that the young woman's behavior is chastised without mention of the young male partner also involved in this behavior. The idea of promiscuous women does not address male sexual behavior, further illustrating the gender disparities in terms of acceptable sexual behavior.

Respondents perceived that if someone is infected with HIV, they "look skinny" or that there was "no way to tell because they might not know." The latter statement was followed by "that's why I'm waiting until I get married." and "you have to use a condom because no one may know [if they are infected or not]." These responses suggest that in the age of AIDS, some young people will postpone sex while others will opt to use a condom.

Similar to findings in the quantitative data, there were low levels of knowledge about vertical transmission of HIV. In general, group participants were unclear as to whether or not a mother could pass HIV to her unborn child. One young woman stated, "If a man has AIDS and gives it to a lady and if she gets pregnant, she can give it to the baby." However, contrary to quantitative findings, none of the participants viewed the use of birth control pills as an effective method to prevent transmission. This contradicts findings in the quantitative data where thirteen young women answered this question wrong.

Participants were asked what could an individual do to prevent becoming infected and the responses ranged from abstinence to getting regular physical examinations. Verbatim responses included: "Get tested," "partners." Almost three-quarters of the respondents (73%) indicated that they would always feel comfortable giving a guy a condom and 89.2 percent

(33 adolescents) responded that they would "always" or "often" talk with a guy with whom they were going to have sex about condom use. This data supports previous findings that adolescent females intend to use condoms to protect themselves against pregnancy and STDs. "Don't do it," "Be a virgin...(laughter), get tested together," "Ask the person," "Go to the doctor and get a physical" and most importantly, "Use a condom every time." The next section discusses condom use among the group participants. The range of responses reflects adolescent attitudes towards sex, sexuality and communication between partners.

Focus group responses of the adolescents echoed the results of other studies that have researched levels of AIDS awareness and knowledge regarding HIV transmission and prevention. Similar to findings by DiClemente, the large majority of the respondents were knowledgeable about how to prevent becoming infected and how HIV is transmitted.[1] The supported quantitative findings. However, given the high rate of HIV infection in young adults, one may assume that adolescents are not practicing the behaviors that they understand to be effective in the prevention of HIV transmission.

Condom Use

> My opinion, well, if that happened, the first thing that I wouldf have though...pregnancy, my mama...and then, the STDs would have come second 'cause, I mean, I'm young and I'm going through that whole thing, I don't want no children and I'm clean.[2]

---

[1]Ralph DiClemente et al. "Comparison of AIDS Knowledge and HIV-Related Sexual Risk Behaviors Among Adolescents in Low and High Risk AIDS Communities," Journal of Adolescent Health 14 (1991) : 236.

[2]Focus Group discussion, Centers for Black Women's Wellness, Plain Talk Program, Atlanta Georgia, March 21, 1997.

Rates of condom use among women who use other forms of contraception are reportedly low.[3] When respondents were asked who had used a condom before, only four people out of the five groups stated that they had done so. One hypothesis to explain such low condom use is that many of the respondents did not want to be identified as being sexually active and often referred to their experiences as experiences of their "friend." If a young girl responded "yes"to this question, she would be indirectly admitting to sexual activity. In comparison, results from the quantitative data showed that 19 percent of the respondents reported condom use as a means of contraception and 84 percent stated that they had used a condom before. Respondents may have been hesitant to admit to sexual behavior in front of others. This discrepancy may be due to an apprehension in admitting sexual activity in groups, since doing so could have immediate consequences such as embarrassment as well as other consequences beyond the focus group depending on the social network:

> "I'm not ready to have kids, I'm getting ready to go to college, I'm getting Depo here...I'm still going to use a rubber. I only probably would stop if I was still with that same person and he was talking comittment...marriage...yeah, only if he was my husband."[4]

Participants were asked reasons why people would use a condom. Overwhelmingly, the first answer in each of the groups was related to pregnancy prevention with respondents making statements such as "to prevent pregnancy," "People use condoms because they do not want to get pregnant," "To prevent pregnancy and STDs." These statements are similar

---

[3]Margaret Frank et. al. "Characteristics and Attitudes of Early Contraceptive Implant Acceptors in Texas," Family Planning Perspectives 24 (1992) : 229.

[4]Focus group discussion, West End Medical Centers, January 16, 1997, Atlanta, GA.

to findings by St. Lawrence which indicate that pregnancy prevention is the primary reason for contraceptive use.[5] The participants' comments may also reflect their awareness of societal norms and expectations for contraceptive behavior. However, the comments may not indicate their actual experiences or beliefs. This could partially explain the gap between knowledge and practice.

It was generally felt that it was the male's responsibility to have condoms but both partners' responsibility to suggest use. Participants mentioned that the cost of condoms and lack of access to them served as a barrier to use. Although condoms are available at clinics, respondents indicated that they did not feel comfortable going to the clinic "just to get condoms." One young woman stated, "I would feel funny going into a store to buy condoms." Another said, "I could never go to a store in my neighborhood...my mama would find out." Feelings of embarassment and discomfort around buying condoms is commonly reported in the literature.

Respondents who had friends who were sexually active indicated that their friends did not think they could contract HIV. One adolescent stated, "..All I hear in school is about having sex and boys. They be scared of diseases. Oh no, they don't do that [use condoms] because they don't think they need to." Many reported that they had friends who used condoms, "...This boy in my eighth grade class used to have condoms all the time. He showed them to all the girls." Whether or not this young man knew how to correctly use a condom is unclear, however, there seems to be an indication that there was some intention

---

[5]Janet St. Lawrence, "African American Adolescents' Knowledge, Health Related Attitudes, Sexual Behavior and Contraceptive Decisions: Implications for the Prevention of Adolescent HIV Infection," Journal of Consulting and Clinical Psychology 61, no.1 (1993) : 106.

to use them since he had them "all the time." Regarding sex with a condom, younger participants did not offer responses to this question while older ones made common statements such as, "It doesn't feel the same" or "some guys say that condoms are too small," suggesting that the older respondents had more experience with condom use than the younger ones:

> About the condom...condom doesn't always work 'cause I have this friend and she slept aruound. She got pregnant and what had happened was the condom broke. It breaks. It leaks. You can't really depend on it to protect you.[6]

Concerns about condom malfunction (coming off, breaking or leaking) surfaced during the discussions as well. All groups reported that condoms can leak or break. This topic came up at numerous points in the focus groups: when discussing contraceptive methods, HIV prevention and reasons for condom use. Interestingly, this concern seemed to be associated with unintended pregnancy and not with possible exposure to STDs. "I have a friend who got pregnant using condoms...it broke. So, you can't really expect it to protect you." Other respondents expressed that they had heard that condoms can leak and for this reason, felt they were unreliable.

Contraceptive Use

> Well you get them...when I got mines taken out. And when you get them out it's harder removing them than putting them in. Mines broke up and just

---

[6]Focus group discussion, West End Medical Centers, Atlanta, Georgia, January 24, 1997.

> the sight of them, tugging and picking at my arm. And the tubes breaking...I don't want to experience that again.[7]

Although the focus of this research was not contraceptive knowledge, questions were asked during the focus groups that explored types of contraceptives that the participants used and contraceptive knowledge since this information informs reproductive decision making and ultimately reproductive rights. When asked to name methods of birth control that they knew, many of the participants appeared to have knowledge of basic contraceptive options although most referred to "Norplant" as "Nordeplant"and Depo Provera as "the shot." Participants discussed their experience and/or what they had heard others say about the pros and cons of the different methods. The data regarding knowledge of contraceptives is interesting, given the mean age (15.4 years) of the participants and their race. Roberts suggests that Depo Provera and Norplant have been marketed to the African American community in a targeted manner in an effort to control population.[8]

Older participants demonstrated more contraceptive knowledge than younger ones and were interested in talking with each other about their experiences with various methods. Some older participants expressed fear of shots and some knowledge regarding the negative side effects associated with using Norplant. When probed as to the type of methods these young women used, one respondent answered, "I use the pill" and stated later that she did not always remember to do take her pills daily. This response is consistent with other

---

[7]Focus group discussion, Centers for Black Women's Wellness, Plain Talk Program, March 21, 1997, Atlanta, GA.

[8]Dorothy Roberts, "From Norplant to the Contraceptive Vaccine" chap. in Killing the Black Body: Race, Reproduction and the Meaning of Liberty, (New York: Pantheon Books, 1997) , 85.

findings that indicate a relationship between inconsistent use of contraceptives and adolescence.[9]

As for the participants who self-reported that they currently use Norplant (6%), some voiced side effects such as weight gain, headaches, irregular menstrual cycles and mood swings. Still others stated that they had used Norplant previously but had switched methods because of the side effects. Reasons for choosing Norplant include problems with taking pills and fear of shots. One older adolescent stated that she tried both pills and Depo Provera but, "I forget to take pills and I'm scared of shots so Norplant suits me best ... and I don't want any more children anytime soon." Two respondents stated that they had experienced considerable weight gain since using Norplant but did not mind this side effect.

Other respondents had family members (mothers, sisters, aunts, older female cousins) who used Norplant, Depo Provera and/or the pill. A number of young women stated that they knew someone who used Norplant. One young woman replied that because of her mother's experience, she was knowledgeable about Norplant, stating "My mama has those things in her arm - Norplant. You keep it in for 5 years. She has had it in for 3 years." Because of the side effects, her mother could not maintain the insertion in her arm for another two years.

Knowledge about Depo Provera was more widespread. This is consistent with quantitative results that indicate that 35 percent of respondents used Depo Provera at the time of the current study. In addition to personal experience, many young women disclosed

---

[9]Christine Galavotti and Daniel Schnell, "Relationship between Contraceptive Method Choice and Beliefs about HIV and Pregnancy Prevention," Sexually Transmitted Diseases 21, no. 1 (1994) , 9.

that they knew someone who also used this method of contraception. For example, one young woman said, "My friend has the shot - she gets it every three months. She get headaches, and they say you can get sick from it." When asked how these young women came to the decision to use "the shot," one young woman stated, "I did not decide to use it...my mother decided for me. She had my brothers and me when she was real young, and she does not want me to get pregnant." Another responded, "My friends told me about it. They said it was easy, but they didn't get sick...I did, I got bad headaches and my menstruation wasn't regular." Two mothers who participated in the current study stated that they chose Depo Provera as a contraceptive method because they did not like the fact that you could see the implants in the arm:

> I know girls I see around school and they all on Depo...there's this one girl and she ain't worried about getting STDs, she can always go to the clinic.[10]

There was some confusion regarding contraceptive knowledge. Some respondents were not aware that in order for Depo Provera to maintain its effectiveness, you had to get an injection every three months. Many thought that the contraceptive would continue to be effective if one was up to three months late. Some respondents stated that they had missed the follow-up shot and had not gotten pregnant. This is significant because advocates of Depo Provera believe that the low-level of user compliance is one of its most beneficial aspects. However, the comments from young women in the current study indicate that they may not fully understand the proper use of this method. Moreover, there is a perception that

---

[10]Focus group discussion, West End Medical Centers, Atlanta, GA, February 21, 1997.

there is no need to use other methods of contraception in between shots, particularly if the user has not gotten pregnant. Given this scenario, condoms would not be used.

There were also other areas where low levels of contraceptive knowledge were found. Respondents were confused about correct oral contraceptive use. They articulated that one could "double up" on oral contraceptives if one or two were missed. Others expressed that after you had the first cycle of pills had been taken, one was protected from pregnancy. Awareness of female condom use was even more limited. None of the participants had ever seen or used one. After the group, the facilitator showed the participants a female condom. The young women made comments such as "it's nasty" or "it's so big" and "it looks hard to use..." Comments such as these indicate possible barriers to female condom use. This is important because the female condom is a method that is within the locus of control of the woman. However, if its use is perceived as cumbersome, even though it is within the woman's locus of control, significant obstacles may be presented.

Other types of contraceptive options included sterilization. In fact, this was viewed as a viable contraceptive option. Respondents stated they knew older women who had been sterilized. It appeared that this option could be chosen if a woman already had the desired amount of children. One young woman said, "My best friend's mama had her tubes tied and they came a loose...she got pregnant again." Others stated "I would do it if I didn't want any more children." Previous research has documented sterilization abuse in communities of color. However, in the aforementioned cases, the decision to not bear any more children seems to be an informed decision.

Finally, for some young women, use of contraceptives or lack thereof was related to perception of need. One young woman stated that some of her peers felt that they did not

need to use contraception "because some of them have not started their menstruation yet and think that they cannot get pregnant." There was a great deal of confusion in one of the groups as to whether or not conception could occur if a woman had not started her menstrual cycle. This misinformation poses a problem for sexually active adolescents. If a young girl believes she cannot get pregnant, she may be less apt to use contraceptives.

Gender

> I say this, this is the way he talking...a lot of girls at school say don't ever break up with him 'cause he is committed. They don't want no STDs and I be like, when people ask me do I trust him, I go, I trust him to do what he's going to do and what happens happens.[11]

As noted earlier, gender influences condom use and thus, also impacts the ability to exercise reproductive rights. The decision to use or not use condoms also has implications for one's sexual partner and can be either positive or negative, depending on the relationship. Although focus group participants initially expressed that condom use is/would be an automatic consideration, further exploration of this topic revealed that factors around the decision to use or not use a condom carries a host of meanings that may not be mutually shared.

All of the young women in the current study expressed the sense that condom use is positive in that it demonstrates concern for oneself and others. However, they often categorized girls who carried condoms as "fast." Few stated that they thought such girls exhibited high self-esteem. It was also expressed that not only males but also females may

---

[11]Focus group discussion, Center for Black Women's Wellness, Plain Talk Program, Atlanta, Georgia, March 21, 1997.

have multiple sex partners, "Some girls do it with everybody...it's like it's a drug." It appeared that young girls who have multiple partners would use condoms with another method of contraception, thus, condom use in this light is viewed as a method to prevent STDs, not pregnancy. On the other hand, males with multiple partners would rely solely on condoms for both pregnancy and STD prevention. Similar findings on male sexual behavior, females in this study indicated an intent to use condoms with a casual partner. However, in the second scenario presented during the focus groups, 80 percent of the respondents agreed to intercourse without a condom at the insistence of the male. Participants stated that they did not want to arouse any suspicions because it could affect the relationship, particularly if they liked the guy and were interested in a long- term relationship. "If you really like him, you won't ask him to use one...you might play him if you do." Another said, "Some girls will have sex without a condom, they might lose the guy if they don't." Trust appeared to be a highly valued attribute in relationships among the adolescents in the current study.

Regardless of the desire or lack thereof to use a condom, talking about condom use does seem to present a problem, particularly if the relationship is long-term. It seems that this could jeopardize sexual intimacy or offend the male. One respondent said, "yes, girls are afraid [to ask him to use a condom] (group agreement), "Some girls just won't do it...they scared of rejection." In other words, a young woman might be more apt to risk possible pregnancy or exposure to STDs than to insist on condom use. Another stated, "I think most of them don't even talk about it...the guy thinks you using something 'cause you ain't got pregnant so no need to use nothing else." Others expressed that condom use would not be discussed if the "guy looked clean." This is interesting given the findings in the quantitative

analysis. Data on HIV prevention knowledge indicated that 84 percent self-reported knowing that you cannot tell a person's HIV status by looking at them.

The idea of condom and contraceptive use as being negotiated is difficult to conceptualize among this population. The concept of negotiation implies that couples communicate about their options and mutually decide upon a method that best suits their needs. Research has documented that such discussions do not take place in the early stages of a relationship, particularly among adolescents. Young women in this study articulated that they felt it was important to use condoms. One young woman said, "I feel it's protecting you from getting pregnant and diseases." Although participants in the current study could clearly state that condoms should be used, their discussion of how to talk about it was another story. "You've got to know how to talk to him, sit down and say, 'I don't want no babies, so we better use something, like a condom...and he says...well...'...I just keep talking to him."

When asked how males and females feel about using condoms, the answers were very interesting. Most respondents stated that they felt comfortable using condoms. A few stated that they had difficulty using them as the condom seemed to "dry them up" or "give them a rash." The young women in this study articulated that they felt males would be more likely to have a condom on him and encourage their partner to use one, "This guy I know pulls them [condoms] out like they are a credit card...he always has them." Conversely, females did not feel that they would insist that their partner to use a condom, but did articulate that they would encourage it. Although almost 70 percent of the respondents indicated that they would not have sex with a guy if he did not use a condom discussion about the role play demonstrated that the majority of females would, in fact, have sex without a condom. This clearly illustrates the disparity between intent to use and actual health seeking behaviors.

The above discussions demonstrate issues African American adolescent females face internally and interpersonally in choosing and using contraceptive methods. The need for dual contraceptive use was not novel to the groups. Adolescent females have at least a moderate level of HIV prevention and transmission knowledge and are cognizant of the importance of using both methods. Furthermore, their experiences with unintended pregnancies, either personally or through their friends or family members, provide real-life examples of the impact of unprotected sexual intercourse. Finally, gender issues such as mistrust and power prevail in sexual decision making for this group.

CHAPTER 7

DISCUSSION: RECONCEPTUALIZING REPRODUCTIVE RIGHTS FOR AFRICAN AMERICAN ADOLESCENT FEMALES

The research questions posed by this study were: (1) Do African American adolescent females know that condoms can prevent transmission of HIV, (2) What factors impact condom use, and (3) What is the relationship between these factors and reproductive rights? In this section some of the significant findings are discussed.

Regarding the first research question posed, these findings support other research which documents that females have higher levels of knowledge than their male counterparts. However, in the literature, there is also documentation that although females indicated that they knew how to prevent HIV, they practiced unprotected sexual intercourse. This indicates that there are other factors that prevent the transference of knowledge into practice. Analysis of the focus group discussions hinted that gender is a barrier to condom use. Gender often manifests as power in male-female relationships. For a young woman, this presents a challenge to even discussing condom use. In fact, the concept of condom negotiation is virtually non-existent in this population. Although many young women indicated that they felt comfortable discussing condom use or carrying a condom, in the scenarios during the groups, these same young women were uncomfortable discussing sex and sexuality. In addition to the obstacles this presents in a relationship, it may also result in misinformation.

If an adolescent female does not feel comfortable raising questions, fears and concerns with their parents or other adults, they may receive incorrect information from their peers. Youth in this study did seem to rely on their peers for information, suggesting that peer influence is considerable.

The second research question sought to identify factors that impact condom use. This researcher found that contraceptive use may or may not impact condom use. Similar to findings of other researchers, if an adolescent is reliant upon more effective methods of contraception such as Depo Provera, oral contraceptives or Norplant, condom use is low. However, some respondents did indicate their sole method of contraception was condoms. Studies have indicated that condoms are the contraceptive of choice among younger adolescents and during the early stages of a relationship. Although whether or not age and/or stage of relationship could not be determined from the current research, future research endeavors should explore this phenomenon.

It is important to note, however, that respondents did indicate that they used dual methods in an effort to prevent pregnancy and STDs. Whether or not condom use among those using other forms of contraception is consistent could not be determined. However, considering that unprotected sexual intercourse on just one occasion could result in HIV infection, condom use that is less than consistent poses a risk to the adolescent. One can assume that young women who use both condoms and another form of contraception do so for a reason - they perceive themselves at risk for contracting STDs as well as becoming pregnant. It would be interesting to ascertain what percentage of this group were consistent users because this would indicate that they are able to apply knowledge to behavior.However,

some users might already have a STD. Therefore, condoms would be used to prevent infecting their partner with a STD.

Gender was also found to impact condom use. This is conceivable since their use is predominately controlled by men. Participants hinted at issues of mistrust if a young woman suggested condom use. Lack of trust is viewed as threatening and possibly not worth risking the relationship. Associated with this was the discussion that the introduction of condom use in an established relationship could harm the relationship. Therefore, one can say that gender impacts condom negotiation.

Condom negotiation assumes that there is a discussion between partners in a relationship and that this form of contraception is mutually agreed. Given the nature of adolescent relationships and their short duration, this discussion generally does not happen in this population. Furthermore, discussions around condom use often imply mistrust or infidelity within a relationship. These qualities are not valued in a relationship and can even jeopardize it. Therefore, condom use in relationships that are perceived to be long-term is often non-existent. Instead, the goal is to prevent pregnancy, not STDs. Essentially, the impact of gender on condom use in the study population is tremendous. It can equate to a matter of life or death. If a young woman's partner does not want to use condoms or the young woman herself is uncomfortable discussing their use, she nor her partner will be protected against HIV.

In response to the research question posed regarding the relationship between HIV prevention, condom use and reproductive rights for African American adolescent females, previous discussions about reproductive rights has not included adolescents. In the study population, reproductive rights is also a matter of life and death. It encompasses gender

relations, historical images of African American women and sexual oppression. Having knowledge about reproductive health could inform reproductive choices such as dual contraceptive use and could, in essence, save the lives of these young women. In its popular context, the foundation of reproductive rights refers to individual control over all aspects of reproduction and is most frequently is used to address issues that relate to the reproductive needs and desires of adult women of childbearing age. Control over reproduction among adolescent females, particularly those who are African American, is not conceived of because unintended pregnancy has such a negative connotation for them. However, an integral component of establishing control over reproduction is knowledge about all aspects of one's reproductive health, including HIV. Reproductive health knowledge should be acquired throughout life. Unfortunately, acquisition of this knowledge most often begins when sexual activity begins. This researcher argues that incorporating adolescents into the reproductive rights agenda would increase their knowledge of themselves. As knowledge is an agent of empowerment, they would be more inclined to make informed decisions about contraception and use methods that are most appropriate to individual needs. This could result in lower levels of unintended pregnancy and STDs.

Efforts at disseminating HIV prevention information have been shown to be effective. Programs have been implemented in public school systems, community programs and reproductive health settings. This is evidenced by the moderate to high HIV prevention knowledge level of African American adolescent females in the current study. This is significant because it demonstrates that respondents have received knowledge about HIV and AIDS from reliable sources. They know how to prevent contracting HIV. However, it is important to note that one of the significant findings in this research was high rate of

confusion around oral contraceptive use and HIV prevention. That is, respondents incorrectly thought that by using oral contraceptives, one would be protected from contracting HIV. Again, this demonstrates the need for improved reproductive health knowledge.

Sexual activity in this small population was not as prevalent as the literature suggested. In fact, there was a strong indication during the focus groups that postponing sexual activity is an accepted group norm, particularly among younger adolescents. As this is a viable option for young people, it should be encouraged and developed by program developers, particularly during the early stages of adolescence and pre-adolescence.

The researcher began this study assuming that issues of control would manifest through contraceptive use or a lack thereof. However, inherent in the literature, there was an underlying assumption regarding the sexual behavior of African American adolescents that echoed historical portrayals of African American women and their sexuality. The underlying premise in the gender analysis also revealed this portrayal. The ideology of African American women as "jezebels" has trickled down into the lives of adolescents. That is, these young women are believed exhibit the fictitious characteristics of a modern-day "jezebel." Due to this realization, an examination of the relationship between contraceptive use, condom use and gender yielded one of the most interesting discoveries in the current study - history has impacted the reproductive rights of African American adolescent females.

The Eurosupremacist nature of research often utilizes methodologies which document the high rates of unintended pregnancy and STDs. For example, one study found that the level of sexual activity was often found to be higher among African American adolescents than among European American adolescents. Other studies did not investigate sexual

behavior specifically, but an analysis of the methods revealed that participants were often of low-income status. This often allows for generalizations about African American women in general and for the perpetuation of sexual notions. These studies also serve as justification for this conceptualization of African American adolescent females and allow for generalizations which are used to justify policies and implement programs that are geared at maintaining control over reproduction. This was clear in the analysis of Norplant and Depo Provera as contraceptive options for women. Although these methods often endanger the lives of the user, they are continuously advocated and subsequently used. Strategies such as these place African American women in a powerless position. This sets the stage for repeated abuse of their reproductive rights, as in the case of the ACTG 076 study.

As history tells us, efforts at reproductive control have been experienced by African American women since enslavement - forced reproduction, forced sterilization, and medical prophylaxis during pregnancy that does not take the health of the mother into consideration. African American adolescent females are not only inheritors of the struggle for reproductive autonomy but also inheritors of the "jezebel" mentality towards their mothers, grandmothers and other ancestresses. And, like their foremothers, efforts are made to control their reproduction also. In contemporary times, efforts at control are accomplished through advocacy of contraceptive methods such as Depo Provera and Norplant. These methods often endanger the reproductive lives of these young women in that they often produce unpleasant and harmful side effects. In addition, they do not offer the user total control over her reproduction because they place her at risk for HIV infection since she is having unprotected sex. The advocates of these contraceptive technologies argue that they give a woman more reproductive control, however, in reality they do not. Ultimately, the entire

African American community is imperiled because African American women are targets of reproductive control.

CHAPTER 8

SUMMARY, RECOMMENDATIONS AND CONCLUSION

Unintended pregnancy among adolescents is a serious social and economic problem. Scholars of various disciplines have concluded this. Most have found that there are significant consequences for teenage mothers. For example, teenage mothers have lower educational levels, are often underemployed, unemployed and/or have decreased income as a result of the aforementioned factors. In addition, unintended pregnancy has ramifications far greater than the aforementioned socioeconomic consequences.

Becoming pregnant indicates unprotected sexual intercourse, a behavior that puts a young girl at risk for HIV infection. This is particularly significant among African American adolescent females because HIV infection in this population is increasing at an alarming rate. It is conceivable that efforts to reduce the teenage pregnancy rate could possibly lower the rate of HIV infection. However, advocacy for contraceptive use in this population focuses on long-term contraceptives which do not provide protection against HIV. Consequently, African American adolescent females are at risk for becoming infected with HIV even though they may not get pregnant. The possibility of becoming infected with a chronic

disease that ultimately impacts one's total health demonstrates a denial of reproductive rights for African American adolescent females.

When considering reproductive health issues such as HIV and unintended pregnancy among adolescents, one can appropriately include the concept of reproductive rights. The term, reproductive rights, refers to the right to have full control over reproduction including access to safe and effective reproductive health services, contraceptive use and the choice of whether or not to reproduce. Unfortunately, this term has most frequently been used to refer to adult women but not all women of childbearing age. The issues of pregnancy prevention and HIV infection are encompassed in reproductive rights since long-term contraceptive use does not provide the safest means for preventing pregnancy. Thus, applying the concept of reproductive rights to adolescent reproductive health is possible.

Reproductive health issues among African American adolescent females are complex. Specifically, the lack of condom use in this population presents an intricately interwoven set of topics that are not easily solved. While a possible solution for preventing pregnancy among adolescents might be condom use, there is evidence this is not probable among African American adolescent females. What is apparent throughout the literature and in the data analysis is that African American adolescents females know how HIV is transmitted and how to prevent becoming infected. Despite this knowledge and the threat of heterosexual transmission of HIV, they continue to engage in unprotected sexual intercourse. This practice has been viewed in a number of ways. For example, adolescents are described as perceiving themselves as invulnerable or perceive pregnancy prevention as a higher priority than HIV prevention. Thus, they do not use condoms. These explanations may offer pieces

of the puzzle, however, they do not explain the entire puzzle. What is apparent, yet is not clearly identified in the literature is how the intervening variables of race, class and gender influence the reproductive behavior of these young women.

The intervening variables of race, class and gender add yet another level of complexity to the issue of reproductive health and reproductive rights for African American females. This research began with a focus on one aspect of this analysis - gender. However, after providing situational analyses within a historical framework, it is evident that historical events impact the perception of reproductive rights for African American women. In addition, African American women, in this case, African American adolescent females, are affected by the historical perception of their sexuality and reproductive behavior. As this is the case, the variables of race and class also impact reproductive rights in the population under investigation.

The experiences of African American women and reproductive health have echoed their other experiences in the United States in that they have been racist. As stated earlier, African American women were categorized as efficient reproducers for the unpaid labor force during enslavement and were also denied participation in the birth control movement during Reconstruction. Because of the historically ingrained perception of African Americans, especially women, practices by white women and white men was not questioned, even though their actions ultimately jeopardized the reproductive health of African American women. African American women have long been viewed as being sexually insatiable and promiscuous. The ideology of "jezebel" has influenced the development of reproductive health policies throughout history. This racist controlling image developed during

enslavement, placed contemporary struggles for reproductive autonomy within a framework that continued to deny African American women this fundamental right. Racism has been the ideological underpinning in issues such as the development of the birth control movement, forced sterilization and medical treatment for HIV positive women.

The examination of the contemporary health issue of HIV infection and its relationship to reproductive health revealed yet another stereotypical image. In this case, the study population, who were predominately women of color, were perceived as endangering their unborn children's lives through their irresponsible behavior. These women are also viewed as being significant contributors to the cycle of poverty since they were low-income. The image of the "welfare mother" is the controlling image that was used to justify policies that aim to reduce the rate of vertical transmission but also endanger the health of the mother. Consequently, the right to safe and effective reproductive health services were denied to the women in the ACTG 076 study.

The underlying racist assumptions in the development of the birth control movement and the ACTG 076 study are not unique. It is these assumptions that have informed the behavior of health policy advocates and the guidelines they develop. For example, policies such as the protocol developed for AZT prophylaxis for HIV positive pregnant women have been developed as a result of perceptions about African American women and their sexuality. Racism has impacted continually on policy and directly on the lives of African American women.

The application of a race, class, gender analysis on reproductive rights for African American adolescent females yields that this group has also been denied reproductive

autonomy. Considering that these young women are inheritors of the aforementioned struggle, they are also inheritors of controlling images. This is evident in the literature. Scholars of various disciplines have asserted that African American adolescent females who are most at risk for unintended pregnancy are often members of a household which is headed by a single parent, low-income and where the mother or older sister also experienced an unintended pregnancy as an adolescent. This profile implies that these young women come from homes where there are "welfare mothers." The description also implies that values are virtually non-existent in these types of households.

As young African American adolescent females seek reproductive health services, this image continues to accompany them. It impacts the type and quality of services they receive. If a young woman is perceived as coming from a low-income family certain assumptions are often made about her educational level and values. For example, low-income women may be perceived as being incapable of using contraceptive methods that require a moderate to high level of user compliance (e.g., oral contraceptives). Therefore, methods that require low-levels of user compliance are implemented. As described earlier, these methods do not offer the user protection against HIV. However, in this population, preventing pregnancy is more important to the client and the provider than preventing HIV.

The provider also accepts the historical images of African American women and their reproduction. The sheer number of policies that are developed and advocated which control reproduction is evidence of this acceptance. Thus, providers may exhibit behaviors that deny their client her reproductive rights. In an effort to transform this, providers should be

considered agents of change for the population they serve. Any other characterization is an obstacle to the client. Furthermore, if providers are not advocates for change, the problems in the community (e.g., HIV infection and unintended pregnancy) are not effectively addressed and feasible solutions cannot be developed and/or implemented.[12]

Ultimately, reducing the amount of children born into poverty is believed to offer a solution to the social and economic problems that plague American society. Despite the obvious irony in this perception, efforts to reduce unintended pregnancy through long-term contraceptive advocacy (e.g., Norplant and Depo Provera) are even more ironic. That is, if African American adolescent females who are at risk for unintended pregnancy prevent becoming pregnant but get infected with HIV, the exorbitant cost of medical care would present an additional economic problem in the United States. Furthermore, given the reality that these methods are not 100 percent effective, it is possible that pregnancy could occur. In the aforementioned scenario, not only have these young women been denied their right to reproductive freedom by putting themselves at risk for HIV infection, they may also be targets of policies that will reduce vertical transmission yet could endanger the health of the mother. Consequently, reproductive freedom has been denied on two fronts - safe and effective contraceptives and safe and effective reproductive health services.

The apparent solution to preventing unintended pregnancy is dual contraceptive use. However, research has shown that this is not as easy as it seems. An investigation into the impact of gender on contraceptive use demonstrated that each gender tends to use

---

[12]Patricia Rodney, "Public Health Professionals: Community Advocates or Impediments to Change?" Paper presented at the 23rd Annual Third World Conference, Chicago, 1997.

contraceptive measures within their locus of control. That is, females use hormonal methods and males use barrier methods. Discussions with African American adolescent females about condom use supported this. They felt that the responsibility for having a condom and to suggest its use was on the male.

Analysis of the quantitative and qualitative data on attitudes about condom use indicated that although African American adolescent females have a desire to prevent STDs, they may not implement health seeking behaviors such as condom use if their partner is not supportive. It is clear that this presents a significant problem for African American adolescent females. Essentially, if a young woman indicates her desire to use a condom but her partner does not want to, they will have unprotected sexual intercourse. In this case, the lack of protection from HIV does not happen because of a lack of knowledge, it happens because of a sense of powerlessness on the part of the adolescent female to negotiate condom use.

The synthesis of the historical information on African American women and reproduction with data analyses suggest that the powerlessness and oppression that African American women have faced since being brought to the United States has been transferred from generation to generation. The behaviors that have continually caused African American women to be subjugated and oppressed under Eurosupremacy have also been perpetuated by white Americans. The manifestation of racist ideologies into oppressive practices and policies has, over the course of time, resulted in internalized oppression for African American women. This may offer an explanation for their low level of condom use. That is, African American adolescent females may not use condoms because of a feeling of

powerlessness that is a result of continual oppression. They have also been conditioned to believe that they cannot use condoms because they are seen as a male method. The perception that condoms are a male controlled method demonstrates the infiltration of racism and sexism into contraceptive use. Thus, although the partners of African American women may not be racist, they too, exhibit oppressive behavior because of their indoctrination into Eurosupremacist thought. Finally, powerlessness is also a result of a lack of advocacy for adolescent reproductive health. They are powerless in this situation because no one advocates for them. Considering the impact of race, class and gender on the reproductive rights of African American adolescent females, it appears that current programs and policies that address reproductive health need to be modified. The goal of reproductive rights policies should be to empower adolescent women to develop a sense of control over their sexual and reproductive lives. This, in turn, could transform the social context in which they are viewed. As a result, unintended pregnancy could realistically result from such a transformation.

Reproductive rights policies that take into account the impact of the race, class, gender analysis on the reproductive health of young African American women are critical to effectively address unintended pregnancy and its related issues. These policies are not developed as a reaction to the current crisis state of African American adolescents and their sexual behavior, but rather, are the result of meaningful discourse about the lives of the young women they seek to empower. As reproductive health encompasses various aspects, (e.g., family planning, STDs/HIV) policies that are developed should be designed to ensure that African American adolescent females are offered the opportunity to exercise their

reproductive rights. Specific recommendations that outline actions to be taken at various levels are included at the end of this chapter.

The first level of transformation and policy development should take place at the point where policy is developed and advocated. At this level the health care system plays a significant role. By improving quality of care for adolescent African American females, an environment where reproductive rights can be exercised would be created.

It is the responsibility of governments to enact policies whose purpose is to improve reproductive health services among all women of childbearing age. State departments of health, other government agencies, policy organizations and outside donors are all active with pregnancy prevention programming, policy development and implementation. These agencies can take a leading role in developing programs and policies that empower, protect and promote the health of African American adolescent females and their partners.

Reproductive health services and programs should be "user friendly." That is, they should be accessible and maintain a high quality of care. Programs should include a full range of high-quality reproductive health services to all that want and need them. Examples of services offered include, but are not limited to, condom negotiation workshops, HIV prevention education, and promote health seeking behaviors such as condom use through participation in health fairs and events (e.g., World AIDS Day). If such services are offered, efforts at controlling reproduction are replaced with goals targeted toward reducing gender disparities, achieving reproductive rights and ultimately, human welfare.

Another suggested contribution to the reconstruction of current policy is the improvement of quality of care from the point of service delivery. Too often the training for

health care professionals is based on hierarchical models that do not encourage participatory decision-making. Therefore, it is important to provide training for health care professionals that stresses the benefits of informed choice, alternative educational strategies that disseminate information to non-traditional clients (e.g. illiterate women, or women with low levels of formal education) and other information relevant to their target population. Health care providers should be required to participate in periodic staff development courses. The content of such courses should include cultural competency, contraceptive technology information and HIV/AIDS updates.

In order to develop policies and procedures that are beneficial in reducing the rate of HIV infection and preventing pregnancy, it is important to talk to the young women themselves. By doing so, an interdisciplinary, multicultural approach is developed which is more likely to have relevance to the experiences of the target population. This approach should be integrated into pregnancy prevention efforts.

The academy is the vehicle through which theory development and building occurs. Theoretical application may not be feasible because researchers may not have contact with the study population. Thus, theories developed are often practical on paper, but not in application. In order to address this issue, the academic community should establish a research agenda that actively provides interaction between the researcher and the "researched." Such an approach could offer significant contributions to the development of theory as well as viable solutions to the reproductive health needs of African American

women, including adolescents. This agenda should take into account the impact of race, class and gender on the delivery of services, prevention and manifestation of disease.

Furthermore, as stated earlier, one of the main reasons that the reproductive rights of African American adolescent females is denied is her historical image. Acceptance of this image translates into low self-esteem and a powerless position. African American women need to recognize the urgency of condom use. By being able to negotiate condom use, the negotiator is empowered and gains control over her reproductive health. This can build self-esteem. Governmental agencies and private organizations can play a significant role in transforming this image and empowering African American women, including adolescents. The Centers for Disease Control and Prevention and other domestic organizations such as United Way often set priorities for research and funding of activities. Therefore, these organizations can mandate the types of programs developed and contribute to policy development. New programs that are developed should be required to incorporate specific components that seek to build self-esteem among African American adolescent females. One such component might incorporate a historical perspective when teaching health education and disseminating other types of knowledge.

It is generally accepted that behavior modification can also increase self-esteem. Numerous programs have shown that behavior can be changed when people are empowered with knowledge, skills, motivation and encouragement. However, this requires significant effort at the individual level. By developing and nurturing skills such as decision-making

and assertive communication, adolescent females are empowered to take individual action against pressures for unwanted or unprotected sex.

Another suggested policy recommendation is at the community level. Community activists, members of the clergy, teachers, adolescents and other gatekeepers should be trained in HIV prevention and be trained as peer educators or mentors. Individuals who are already accepted by the community have already established a rapport and can better serve as advocates for condom use. An additional component to the aforementioned recommendation is the development of a parent-child communication program where issues such as contraceptive use and sexuality can be discussed in a non-threatening atmosphere.

Finally, in order to dismantle the existing paradigm of race, sex and class oppression, it will be necessary to eradicate Eurosupremacy. Clearly this is a monumental task. The history of people of African descent in the United States includes a history of struggle. The nature of this struggle is for the ultimate liberation of all African people from oppression. An important part of this history is the struggle for African American women to obtain reproductive autonomy. In order for this to happen, the existing structure must be challenged. While it is recognized that movement towards conscious liberation is an evolving process, there are actions that can be taken in an effort to eradicate race oppression. For example, the impact of gender on the reproductive rights of African American women must be analyzed from a practical perspective. This analysis will frame the discussion of sexual relations in our community. In conjunction with a gender analysis, women and men of African descent need to engage in on-going discussions about sexuality and gender relations. This will allow a healthier image of African American women to be developed and

established. It will also provide a forum where the needs of each gender can be heard and viable options developed.

The controlling images that have been used to subjugate African American women need to be eradicated. These images have become deeply ingrained in the fabric of American society and are used on many fronts to justify racism, classism and sexism. Although these personifications currently play a significant role in society, acknowledging the images as they appear and consciously striving to overcome them will help to decrease their power.

In conclusion, the findings in the current study suggest that there is a need for the establishment and implementation of a reproductive rights policy. Therefore, it is believed that if the aforementioned recommendations are implemented, there will be a shift in current thinking about African American adolescents and their sexuality, including the right to reproduction. The recommendations made addressing policy at the governmental level are broad approaches while those recommendations that are aimed at the young women themselves have the potential to have a more direct impact on their lives and are more easily measured.

The agenda for a reproductive rights policy encompasses human rights and addresses gender inequities. Such a policy establishes the legal and structural framework within which all women of childbearing age are able to exercise reproductive self-determination. Ultimately, it is designed to provide a haven of rights by which the sexual and reproductive health needs of adolescent African American women and their partners can be addressed. reproductive rights have long been denied for African American women of all ages. While the implications for this have always been significant, in the age of AIDS, denial of Reproductive rights means the possibility of experiencing an unintended pregnancy and the

possibility of becoming infected with HIV. Simply put, it can mean death, because this is such a grave consequence and is preventable, it is necessary to address this issue in order to improve the health status of this population.

In order for African American adolescent females to control their own reproduction safely and effectively, they must be given the opportunity to manage their own health and sexuality. Reconceptualizing reproductive rights to include gender and class issues will also provide a platform for the voices of activists from other issues to be heard. Reconstructing reproductive rights through the development of reproductive rights policy and program improvements allows for service providers to participate in a new perspective on improving reproductive health. African American adolescent females alone cannot change current perceptions; health care providers alone cannot do it either; nor will policy makers or activists by themselves. It will be through the unified efforts of all players towards a common goal that will transform the context of a social/political environment that threatens the reproductive freedom of all women.

Recommendations

- State departments of health, education and other relevant agencies should develop programs and policies that are designed to empower, protect and promote the health of African American adolescent females, their partners and their children.
- Reproductive health services that are sponsored by public agencies and private organizations should be accessible to the clients they serve.
- Reproductive health programs should offer services that empower clients so that they can make informed decisions.
- Strategies developed should consider the needs of special populations, such as women who may be illiterate or have a low levelof formal education.
- Health care providers should be encouraged to educate themselves about new technologies, emerging issues and other relevant topics that could improve the quality of service offered to the client.
- Educators and other academicians should establish a research agenda that is interactive between the study population and the researcher.
- Government agencies, private organizations, communities and individuals have a responsibility to assist in the transformation of the negative image of African American women.
- Community leaders can play a significant role in efforts to reduce HIV transmission in their community. They can be trained as HIVprevention educators, resource people and mentors.

APPENDIX 1

CLARK ATLANTA UNIVERSITY
AFRICANA WOMEN'S STUDIES DEPARTMENT

AN EXAMINATION OF THE REPRODUCTIVE RIGHTS AMONG AFRICAN AMERICAN ADOLESCENT FEMALES

CONSENT FORM

I am a graduate student from Clark Atlanta University. I am collecting information for my final project to find out more about the health of African American adolescent females in Atlanta. I am asking for your participation in a group discussion and in filling out a survey. So that I can make certain that I get all of the information during our discussion, I will make a tape recording of the group. You are free to decline to discuss any topics you wish. The discussion and survey will not put you in any physical risk.

The recordings and the surveys will be kept strictly confidential and will not be made available to anyone else. I will not use your name or any other information that could identify you (like what you look like, where you live, etc.).

Please feel free to contact me at (404) 239-1646 if you have any questions about the research or the discussion.

I hereby consent to volunteer to participate in this study.

_____
Participant Signature

_____
Participant Name (please print)

_____
Date

_____
Investigator's Signature

_____
Investigator's Name

APPENDIX 2

CLARK ATLANTA UNIVERSITY
AFRICANA WOMEN'S STUDIES DEPARTMENT

SURVEY

Please answer the questions by placing a **"X"** *in the box. Choose only one answer for each question. If you do not feel comfortable answering a question, you do not have to answer it, just go on to the next one.* **Y= Yes; N= No; DK = Don't Know**

1. Using a condom will protect you from getting AIDS. □Y □ N □ DK
2. You can reduce your chances of becoming infected by using a condom every time you have sex. □Y □ N □ DK
3. AIDS can be cured. □Y □ N □ DK
4. Only homosexuals get AIDS. □Y □ N □ DK
5. You can get AIDS by holding hands. □Y □ N □ DK
6. Mothers can pass AIDS onto their babies while they are pregnant. □Y □ N □ DK
7. You can tell if a person has AIDS by looking at them. □ Y □ N □ DK
8. If someone has AIDS, they may never have symptoms and may feel healthy, but can infect others. □Y □ N □ DK
9. You can reduce the chance of becoming infected with AIDS by using birth control pills. □Y □ N □ DK
10. Do you use condoms? □ I do not have sex □ Yes □ No
11. How often do you/would you use a condom?
    □ Always □ Often □ Sometimes □ Rarely □ Never
12. Do you/Would you use a condom to: (CHOOSE ONE)
    □ prevent pregnancy
    □ prevent sexually transmitted diseases like herpes, gonorrhea, or syphilis
    □ both
    □ I don't use condoms
13. Did you/Would you use a condom the last time you had sex? □ Yes □ No
14. I can/could ask my boyfriend to use a condom.
    □ Always □ Often □ Sometimes □ Rarely □ Never
15. If a guy does not have a condom with him, I would feel/do feel comfortable giving him one.
    □ Always □ Often □ Sometimes □ Rarely □ Never
16. If a guy does not want to use a condom, I would not/will not have sex with him.
    □ Always □ Often □ Sometimes □ Rarely □ Never
17. Having sex without using a condom shows/would show more love:
    □ Always □ Often □ Sometimes □ Rarely □ Never
18. Sex does not/would not feel as good with a condom.
    □ Always □ Often □ Sometimes □ Rarely □ Never

19. I can/could talk to a guy I am going to have sex with about using a condom.
    □ Always □ Often □ Sometimes □ Rarely □ Never
20. Using a condom with my boyfriend means that I am/would be fooling around on him.
    □ Always □ Often □ Sometimes □ Rarely □ Never

Finally, the last section of the questionnaire obtained demographic data. The questions in this section are:

23. How old are you? _____
24. What county do you live in □ Fulton □ DeKalb □ Other_____
25. Are you in: □ middle school □ high school □ college □other
26. Do you have children? □ Yes □ No
27. If yes, how many children do you have? □ 0 □ 1 □ 2 □ 3 □ 4
28. What form of birth control do you currently use? (Please check only one)
    □ Birth control pills □ Norplant (implants) □ Depo Provera (shot)
    □ Rhythm method □ abstinence □ other _____
    □ I do not use birth control
29. How long have you used this method?
    □ less than 6 months □ one year □ 2 years
30. Do you use: □ Medicaid □ private health insurance □ pay cash for services
    □ other _____

APPENDIX 3

FOCUS GROUP GUIDE

1. What do you know about HIV?
2. What do you know about AIDS?
3. How are the two different?
4. How do people get infected with HIV?
5. How can people protect themselves from contracting HIV?
6. What are some of the reasons that people use condoms?
7. If you were to use a condom, what would be the main reason for using them?
8. Would you use condoms with a guy that you were in a relationship with for a while?
10. How do you feel about having sex with a condom?
11. How frequently do girls encourage their sex partners to use condoms.
12. How do they feel about using condoms?
13. How frequently do guys encourage their sex partners to use condoms?
14. How do guys feel about using condoms?
15. What would you do if you wanted to use a condom during sex and the guy didn't?
16. How do you feel about talking with a guy about using birth control?
17. How do you feel about talking with a guy about using condoms?
18. What would you do if you wanted to use a condom and the guy did not?

Scenario 1: You met a guy that you want to get with. He's real popular at school and he has asked you to have sex with him. You have decided that you will only have sex with him if he agrees to use a condom. He says he does not use condoms. What do you say?

Scenario 2: A girl that you have liked for a long time says she will finally go to the movies with you. After the movie, she tells you that no one is home at her house and invites you in. She tells you that she wants to have sex with you. You also want to have sex with her. You have a condom in your wallet because you always use them to protect yourself. She says it does not feel the same with a condom. What do you say?

BIBLIOGRAPHY

American Red Cross. HIV/AIDS Facts Book. Washington, DC: American Red Cross, 1996.

Alan Guttmacher Institute. Sex and America's Teenagers. New York: Alan Guttmacher Institute, 1994.

Armstrong, Elizabeth and Alicia Pascale. Pregnant and Parenting Teens Face Health Risks, Academic Failure and Poverty Washington, DC: Center for Population Options: 1990.

Anderson, John, Laura Kann, Deborah Holtzman, Susan Arday, Ben Truman, and Lloyd Kolbe. "HIV/AIDS Knowledge and Sexual Behavior Among High School Students." Family Planning Perspectives 22, no. 6 (1990): 252-255.

Body Health Resources Corporation. "Mother-to-Infant HIV Transmission 076 Update: Can We Believe Them?" New York: Body Health Resources Corporation, 1997.

Brown, Larry, Ralph DiClemente, and Teron Park . "Predictors of Condom Use in Sexually Active Adolescents." Journal of Adolescent Health 13 (1992): 651-657.

Buechler, Steven M. Women's Movements in the United States: Woman Suffrage, Equal Rights and Beyond. New Brunswick, NJ: Rutgers University Press, 1990.

Caldas, Stephen and Mike Males. "Teen Pregnancy: Why it Remains a Serious Social, Economic and Educational Problem in the U.S.–Comment/Reply." Phi Delta Kappan 75, no.5.

Catania, Joseph, Thomas J. Coates, Ruth Greenblatt, Margaret Dolcini and Susan Kegeles. "Predictors of Condom Use and Multiple Partnered Sex Among Sexually Active Adolescent Women." American Journal of Diseases of Children 143 (May 1989): 514-524.

Collins, Patricia Hill. Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment. New York: Routledge Press, 1991.

Cook, R. and M.I. Plata. "Women's Reproductive Rights." International Journal of Gynecology and Obstetrics 46 (1994): 215-220

Corrêa, Sonia and Rebecca Reichmann. Population and Reproductive Rights: Feminist Perspectives from the South. London: Zed Books, 1994.

Davis, Angela. Women, Race and Class. New York: Random House, 1981.

Detzer, Mark, Sally Wendt, Laura Solomon, Ellen Dorsch Berta Geller, Jay Friedman, Hanna Hauser, Brian Flynn, and Anne Dorwaldt. "Barriers to Condom Use Among Women Attending Planned Parenthood Clinics." Women and Health 23, no. 1 (1995): 91-102.

DiClemente, Ralph, Cherrie Boyer, and Edward Morales. "Minorities and AIDS: Knowledge, Attitudes and Misconceptions Among Black and Latino Adolescents." American Journal of Public Health 78, no. 1 (January 1988): 55-57.

_____, Jim Zorn, and Lydia Temoshok. Adolescents and AIDS: A Survey of Knowledge, Attitudes and Beliefs About AIDS in San Francisco." American Journal of Public Health 76, no. 12 (December 1986): 1443-1445.

_____. "The Emergence of Adolescents as a Risk Group for Human Immunodeficiency Virus Infection." Journal of Adolescent Research 5, no.1 (1990) : 7-17

_____, Larry Brown, Nancy Beausoleil, and Mark Lodico. "Comparison of AIDS Knowledge and HIV-Related Sexual Risk Behaviors Among Adolescents in Low and High Risk AIDS Prevalence Communities." Journal of Adolescent Health 14 (1991): 231-236.

Dixon-Mueller, Ruth. Population Policy and Women's Rights: Transforming Reproductive Choice. Westport,CT: Praeger Publishing Co., 1993.

Eldridge, Gloria, Janet St. Lawrence, Connie Little, Millicent Shelby, and Ted Brasfield. "Barriers to Condom Use and Barrier Method Preferences Among Low-Income African-American Women." Women and Health 23, no.1 (1995): 73-89.

Feringa, Barbara, Sarah Iden, and Allen Rosenfeld. "Norplant: Potential for Coercion." In Norplant and Poor Women, ed. Sarah Samuels and Mark Smith, 53-64. Menlo Park, CA: Kaiser Foundation, 1992.

Fleisher, Jay, Rubie Senie, Howard Minkoff, and James Jaccard. "Condom Use Relative Knowledge of Sexually Transmitted Disease Prevention, Method of Birth Control, and Past or Present Infection." Journal of Community Health 19, no. 6 (1994): 395-407.

Frank, Margaret, Bateman, Louise and Alfred Poindexter. "Planned Condom Use by Women with Norplant Implants." Advances in Contraception 9 (1993): 227-232.

Frank, Margaret, Alfred Poindexter, Michael Johnson, and Louise Bateman. "Characteristics and Attitudes of Early Contraceptive Implant Acceptors in Texas." Family Planning Perspectives 24 (1992): 208-213.

Galavotti, Christine and Daniel Schnell. "Relationship Between Contraceptive Method Choice and Beliefs About HIV and Pregnancy Prevention." Sexually Transmitted Diseases 21, no. 1 (1994): 5-7.

Georgia Department of Human Resources, Epidemiology and Prevention Branch. HIV/AIDS in Georgia. Atlanta: Georgia Department of Human Resources (1996).

_____. "HIV in Georgia - An Update," Atlanta: Georgia Department of Human Resources, Office of Communications (July 1996).

_____."Teenagers, AIDS, and Sexually Transmitted Diseases in Georgia: Fact Sheet." Atlanta: Georgia Department of Human Resources (January 1995).

Giddings, Paula. From When and Where I Enter: The Impact of Black Women on Race and Sex in America. New York: Bantam Books, 1982.

Gordon, Linda. Woman's Body, Woman's Right: A Social History of Birth Control in America. New York: Grossman Publishers, 1976.

Gutman, Herbert G. Slavery and the Numbers Game: A Critique of Time on the Cross. Chicago: University of Illinois Press, 1975.

Guttmacher, Sally, Lisa Lieberman, Wai Hoi-Chang, David Ward, Alice Radosh, Yvonne Rafferty and Nicholas Fruedenberg."Gender Differences in Attitudes and Use of Condom Availability Programs Among Sexually Active Students in New York City Public High Schools." Journal of the American Medical Women's Association 5, no. 3 (1995): 99-102.

Hein, Karen. "AIDS in Adolescence: Exploring the Challenge." Journal of Adolescent Health Care 10 (1989) 10S-35S.

Hingson, Ralph, Lee Strunin, and Beth Berlin. "Acquired Immunodeficiency Syndrome Transmission: Changes in Knowledge and Behaviors Among Teenagers. Massachusetts Statewide Surveys, 1986 to 1988." Pediatrics 85 (1990): 24-29.

Howe, Michael. "Zidovudine for the Prevention of HIV Transmission from Mother to Infant." AIDS Information Newsletter: Women and HIV Infection: Part XIII. 18 November 1994.

Humphries, Helen and Karl Bauman. "Condom Use by Norplant Users at Risk for Sexually Transmitted Diseases." Sexually Transmitted Diseases 21, no. 4 (1994): 217-219.

Jones, Bess. "Repeat Teen Deliveries in Fulton County." Journal of Adolescent Growth 78 (January 1989): 57-65.

Kahn, Joan, Ronald Rindfuss, and David Guilkey. "Adolescent Contraceptive Method Choices." Demography 27, no. 3 (August 1990): 323-335.

Kegeles, Susan, Nancy Adler, and Charles Irwin. "Adolescents and Condoms: Associations with Beliefs of Intentions to Use." American Journal of Disease and Children 143 (August 1989): 911-915.

Kids Count, Missouri. "African-American Teens Face Much Higher Risks for Pregnancy and Birth." St Louis: University of Missouri-St.Louis, 1996.

Kozlowski, Karen, Walter Ohlausen, Albert Warren, Ann Hendon, Pat Davis, and Rickert Vaughan "Knowledge and Attitudes of Norplant Among Adolescent Females." Adolescent Pediatric Gynecology 7 (1994): 69-75.

Langer, Lilly, Rick Zimmerman, and Jennifer Katz. "Which is More Important to High School Students: Preventing Pregnancy or Preventing AIDS?" Family Planning Perspectives 26, no. 4 (July 1994): 154-159.

Leigh, Barbara, Diane Morrison, Karen Trocki, and Mark Temple. "Sexual Behavior of American Adolescents: Results from a U.S. National Survey." Journal of Adolescent Health 15 (1994): 117-125.

Leland, Nancy, Donna Petersen, Mary Braddock, and Greg Alexander. "Variations in Pregnancy Outcomes by Race Among 10-14 Year Old Mothers in the United States." Public Health Reports 110, no. 1 (January 1995): 53-58.

Leland, Nancy and Richard Barth. "Gender Differences in Knowledge, Intentions and Behaviors Concerning Pregnancy and Sexually Transmitted Disease Prevention Among Adolescents." Journal of Adolescent Health 13 (1992): 589-599.

McCann, Carole R. Birth Control Politics in the United States, 1916-1945. Ithaca, NY: Cornell University Press, 1994.

Mason, Winslow. "Norplant Linked to Women of Color" The Philadelphia Tribune, 9 July 1993, 1(A).

Morris, Leo, Warren, Charles and Sevgi Aral. "Measuring Adolescent Sexual Behaviors and Related Health Outcomes." Public Health Reports 108: supplement 1 (1993): 31-36.

The Nation Alexander Cockburn, "Norplant and Social Cleansers." 259, no. 4, 25 July 1994: 116-117.

National Library of Medicine-HIV/AIDS Treatment Information Service. "About the Women in the AZT Study." Rockville, MD: National Library of Medicine, 1997.

Philadelphia Inquirer. "Can Contraception Reduce the Underclass?" The Philadelphia Inquirer, 12 December 1990.

Plichta, Stacy, Carole Weisman, Constance Nathanson, Margaret Ensminger, and J. Courtland Robinson. "Partner-Specific Condom Use Among Adolescent Women Clients of a Family Planning Clinic." Journal of Adolescent Health 13 (1992): 506-511.

Reed, James. From Private Vice to Public Virtue: The Birth Control Movement and American Society Since 1830. New York: Basic Books Inc., 1990.

Rickert, Vaughan, Susan Jay, Anita Gottlieb, and Christie Bridges. "Adolescents and AIDS: Female's Attitudes and Behaviors Toward Condom Use and Purchase." Journal of Adolescent Health Care 10 (1989): 313-316.

Rickert, Vaughan, Susan Jay, Anita Gottlieb, and Christie Bridges. "Adolescents and AIDS: Female's Attitudes and Behaviors Toward Condom Use for Disease Prevention Among Adolescent Users of Oral Contraceptives." Family Planning Perspectives 23 (1989): 35-43.

Roberts, Dorothy. Killing the Black Body: Race, Reproduction and the Meaning of Freedom. New York: Pantheon Press, 1997.

Rodney, Patricia. "Public Health Professionals: Community Advocates or Impediments to Change?" Paper presented at the 23rd Annual Third World Conference, Chicago, 1997.

Rosenberg, Peter S., Ralph Biggar, and James Goedert. "Declining Age at HIV Infection in the United States." New England Journal of Medicine 330, no. 11 (1994): 789.

Ross, Loretta. "Reproductive Rights and African American Women." Atlanta,1993 mimeographed.

St. Lawrence, Janet. "African-American Adolescents' Knowledge, Health Related Attitudes, Sexual Behavior, and Contraceptive Decisions: Implications for the Prevention of Adolescent HIV Infection." Journal of Consulting and Clinical Psychology 61, no. 1 (1993) : 104-112.

Seitz, J. and J. Munn. "Adolescents and AIDS: Knowledge and Attitudes." Adolescence 28, no. 111 (1993) :609-619.

Sonenstein, Freya, Joseph Pleck, and Leighton Ku. "Sexual Activity, Condom Use and AIDS Awareness Among Adolescent Males." Family Planning Perspectives 21, no. 4 (1989): 152-158.

Stevenson, Howard, Gwendolyn Davis, Ellen Weber, David Weiman, and Saburah Abdul-Kabir,. "HIV Prevention Belief Among Urban African-American Youth." Journal of Adolescent Health Care 16 (1995): 316-323.

Stiffman, Arlene, Peter Dore, and Renee Cunningham . "Inner-City Youths and Condom Use: Health Beliefs, Clinic Care, Welfare and the HIV Epidemic." Adolescence 29, no. 116 (1994): 805-820.

Strunin, Lee, Ralph Hingson, and Beth Berlin. "AIDS Transmission: Changes in Knowledge and Behaviors Among Adolescents, 1986-1988." Pediatrics 85 (1990): 24-29.

USA Today: The Magazine of the American Scene. January 1994, 11.

USA Today. Editorial 16 February 1993, 10.

U.S. Centers for Disease Control and Prevention. "What are Young Gay Men's HIV Prevention Needs?" Atlanta: Centers for Disease Control and Prevention National AIDS Clearinghouse, 1996:1.

U.S. Centers for Disease Control and Prevention. "CDC Fact Sheets" Atlanta: Centers for Disease Control and Prevention National AIDS Clearinghouse, 1996:1-7.

University of South Carolina, School of Public Health. Reducing Unintended Adolescent Pregnancy. Columbia, SC: University of South Carolina, 1988.

Walter, Heather, Vaughan Rickert, Deborah Ragin, Alwyn Cohall, Stephanie Kasen, and Robert Fullilove. "Prevalence and Correlates of AIDS-Risk Behaviors Among Urban Minority Students." Preventive Medicine 22 (1993): 813-824.

Weisbord, Robert. Genocide? Birth Control and the Black American. Westport, CT: Greenwood Press, 1975.

Weissman, Carole, Stacy Plichta, Constance Nathanson, Margaret Ensminger, and J. Courtland Robinson. "Consistency of Condom Use for Disease Prevention Among Adolescent Users of Oral Contraceptives." Family Planning Perspectives 23 (1991):3155-3159.

Wilson, Michele, Mariana Kastrinakis, Lawrence D'Angelo, and Pamela Getson. "Attitudes, Knowledge and Behavior Regarding Condom Use in Urban Black Adolescent Males." Adolescence 29, no. 113 (Spring 1994): 13-26.

Wingood, Gina and Ralph DiClemente. "Cultural, Gender and Psychological Influences on HIV-Related Behavior of African-American Female Adolescents: Implications for the Development of Tailored Prevention Programs." Ethnicity and Disease 2 (Fall 1992): 381-388.

Young, Melvina Johnson, "Exploring the WPA Narratives: Finding the Voices of Black Women and Men." in Theorizing Black Feminisms: The Visionary Pragmatism of Black Women, eds. Stanlie James and Abena Busia. London: Routledge Press, 1993.

Zabin, Laurie, Valerie Sedivy, and Mark Emerson. "Subsequent Risks of Childbearing Among Adolescents with a Negative Pregnancy Test." Family Planning Perspectives 26, no. 1 (1994): 212-223.

Zabin, Laurie and Samuel Clark. "Why They Delay: A Study of Teenage Family Planning Clinic Patients." Family Planning Perspectives 13, no. 5 (1981): 205-217.

Zelnick, Melvin and Joseph Kantner. "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan Area Teenagers: 1971-1979." Family Planning Perspectives 12, no. 5 (1980): 230-237.